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MEDICARE PAYMENT FOR PHYSICIAN SERVICES: EXAMINING NEW APPROACHES

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MEDICARE PAYMENT FOR PHYSICIAN SERVICES: EXAMINING NEW APPROACHES

THURSDAY, MARCH 1, 2007

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Stabenow, Salazar, Grassley, Hatch, Smith, Bunning, and Roberts.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

In 1976, the President of Memorial Sloane-Kettering said, "The great secret of doctors, still hidden from the public, is that most things get better by themselves. Most things, in fact, are better in the morning."

Unfortunately, health care costs are not one of those things. Health care spending is growing at roughly twice the rate of inflation. Since the year 2000, Medicare spending on physician services has grown nearly 10 percent a year.

Health care costs will not just get better in the morning. Health care costs' growth has not been uniform across the country. There are wide variations in the volume of services provided to comparable patients. These variations appear both across geographical regions and among physician specialties.

The evidence also strongly suggests that patients are not reaping better health outcomes in exchange for this extra spending. In fact, some evidence suggests that more services may equate with worse health outcomes.

Another thing that will not just get better in the morning is the way that Medicare pays doctors. In 1997, Congress created the system that we have now. Congress created a thing called "Sustainable Growth Rate"—SGR. It was meant to control what Medicare spends on doctors.

But the SGR is not working. If Congress had not intervened, the SGR would have produced steep cuts in physician payments since 2002. If Congress does not intervene, the SGR will continue to produce steep cuts for the foreseeable future. But every year since 2003, Congress has intervened to avert these cuts. The SGR will not just get better in the morning.

We need to establish a sound, predictable system. That is why, in early 2006, Congress asked MedPAC to examine a variety of alternative mechanisms for controlling physician expenditures under Medicare. This morning, MedPAC released its report, and I am looking forward to hearing the Commission's chairman, Glenn Hackbarth, explain what MedPAC found.

Whatever path we choose, we need to ensure that only appropriate evidence-based services are being provided to Medicare beneficiaries. We must strive for a system that demands the highest quality and most efficient use of resources.

Yes, we must defer to the clinical expertise of doctors and other providers in caring for patients, but we must also realize we have a responsibility to control the growth in volume of services so that the Medicare program can be sustained in the future.

Our experience with the SGR has demonstrated that a target-based system that cuts payment rates may not be a very effective way to control the volume of services or overall spending. For some time, MedPAC has encouraged Congress to adopt a variety of measures that will create incentives for quality and efficiency, and many of those recommendations are included in this report, along with some new ones. We will move forward on many of these fronts this year.

Any honest discussion about reforming the current SGR system must also address the elephant in the room: the budget baseline. The budget baseline assumes that Congress will not suspend SGR. Thus, modifying the system in a way that achieves some payment equity over the long term will be extremely costly.

That is why it is important to hear from Peter Orszag, the Director of the Congressional Budget Office. We must be realistic and cost-conscious in mapping our way forward.

Another key question relates to the experience of Medicare beneficiaries. The beneficiaries, after all, are the reason that we are here today. We need to ensure that seniors remain able to get good medical care.

Doctors in my home State of Montana tell me they are committed to serving these patients, and recent studies by MedPAC, GAO, and others suggest that our seniors are not having much difficulty seeing a doctor.

But I do hear reports about doctors in some parts of the country refusing to see new Medicare beneficiaries. They claim that the cost of treating them exceeds their reimbursement. I am concerned that a new generation of doctors is coming of age that may not be as willing to see Medicare beneficiaries. We need to take steps now to ensure that that does not happen.

The challenge of the SGR in health policy is something like that of the AMT in tax policy: they are both three-letter words. [Laughter.] They both stand for real problems that Congress has been ducking for years.

So let us roll up our sleeves. Let us get to work. It is my hope that the MedPAC report will give us a new launching pad for intense discussion of these issues. Let us find reforms that will ensure the efficient use of Medicare dollars. Let us find reforms that will maintain beneficiaries' access to high-quality services, and let

us do more than just "take two aspirin," only to find we have the same problem in the morning.

So, thank you, all who are here. Senator Grassley is almost always here, Johnny-on-the-spot, on time. He is delayed this morning because he is introducing the mayor of Des Moines at a very important occasion, and he will be here very shortly.

But in the meantime, let us now turn to our panelists. We will hear, first, from Glenn Hackbarth, the chairman of MedPAC. He will present the Commission's report on alternatives to SGR, which was requested by Congress in the Deficit Reduction Act of 2005.

He will then be followed by Peter Orszag, the Director of the Congressional Budget Office, who will describe the budgetary outlook of the SGR and implications of reforming it.

We will hear from Dr. Cecil Wilson, chairman of the AMA board of trustees, who will discuss challenges posed by the current payment system and the impact of potential reforms.

Finally, Dr. Byron Thames, a member of AARP's board of directors, will provide insight regarding Medicare beneficiaries' perspective on the current system and potential reforms. Actually, I do not want to say what they are all going to say, because clearly each is going to say what each one wants to say, and I encourage you to do that.

But thank you all for coming, very, very much. There is a light in front of you. Basically it turns red when your time expires. We are going to try to honor that light as much as we possibly can.

Chairman Hackbarth?

STATEMENT OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC

Mr. HACKBARTH. Thank you.

The CHAIRMAN. And I might say, we have agreed to give you 10 minutes rather than the standard 5 so that you can have time to say what you want to say.

Mr. HACKBARTH. I appreciate that. Thank you, Mr. Chairman, Senators. I appreciate the opportunity to discuss our report on alternatives to Medicare's Sustainable Growth Rate system.

As requested in the Congressional mandate, MedPAC has analyzed the pros and cons of expenditure targets in general, as well as the five specific options included in the mandate, namely targets based on geography, separate targets for multi-specialty group practice, targets based on hospital medical staffs, targets based on type of service, and outliers.

In our report, we present two alternative policy paths for your consideration. One of those paths does not include an expenditure target and the other does include an expenditure target.

As you know, MedPAC is a 17-member Commission. We have a wide variety of backgrounds and experiences represented on the Commission: we have clinicians, and health care executives, and academics, and former government officials.

Despite the diversity of the Commission, we have generally been very successful in forging a consensus in our recommendations to Congress. For example, in our March 2007 report to Congress,

which is being separately transmitted to you today, we have nine recommendations to Congress.*

On those nine recommendations, there were only two "no" votes and one abstention. There were 120-some "yes" votes. That is typical of past MedPAC reports. So we take pride in the fact that we are able to take a wide variety of perspectives and forge them into one consensus position to help guide you.

Alas, in this particular case, the SGR, it has not been possible for us to forge a consensus within the Commission about what to do, at least with regard to some aspects of this problem.

So what I have done, to help you understand where Commissioners agree and where we disagree, is to try to break the SGR problem into four dimensions. Before you, you have two pieces of paper, the first of which is labeled "Four Dimensions of the SGR Problem." I am going to be using that as the framework for my comments, so I would ask you to refer to it.

The CHAIRMAN. Yes. We have that here. I think, at least I do. Do other Senators have it? Good. All right.

Mr. HACKBARTH. All right.

So let me begin with the first bullet there: "Encourage Efficiency in the Delivery of Health Care." Obviously that is an important goal. Let me start by defining what we mean by "efficiency." By "efficiency," we mean maximizing the benefit to patients for any given level of expenditure.

In other words, it is not just about reducing costs. If you just reduce cost, and at the same time reduce quality, we do not consider that increasing efficiency. So the objective for the Medicare program is not just cost reduction, but reducing the amount of money we have to spend to get any given level of improvement for Medicare beneficiaries.

There is unanimous agreement within MedPAC that expenditure targets by themselves, target systems like the SGR, do not establish appropriate incentives for efficiency. Indeed, by only constraining the amount paid for individual units of service, an expenditure target may, in fact, induce inappropriate cost-increasing behavior that does not contribute to the benefit of Medicare beneficiaries.

For example, increases in the volume and intensity of service, perhaps as a result of many physicians investing in imaging equipment and then using that equipment more than necessary, can increase costs without commensurate improvements in quality of care. In addition, payments that are too low as a result of an expenditure target may well impede access to quality care for Medicare beneficiaries.

To establish proper incentives to improve efficiency, Congress must pursue a broader agenda. That agenda is briefly summarized in the second handout before you labeled "Increasing Value and Efficiency in the Medicare Program."

Let me briefly describe the four items here. By "Pricing Accuracy," we mean trying to set rates for all types of providers, not

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*For additional information on this subject, *see also,* "Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System," MedPAC, March 2007, available at *http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf.*

just physicians, accurately to reflect the type of patients cared for and the services provided.

There are important reforms that MedPAC has recommended in the physician payment system, the hospital payment system, and the post-acute payment systems to improve pricing accuracy, but much work remains to be done.

The second item, "Coordination of Care," refers to assuring that patients have appropriate continuity of care over time, especially patients who have chronic illnesses and perhaps multiple chronic illnesses.

That involves education of patients, communication with patients between visits, and a variety of supports, as well as sharing information among clinicians about the care given to a given patient.

The third bullet, "Accountability," includes such items as pay for performance and helping physicians understand how their use of resources compares to their peers.'

Then the last bullet, "Information," refers to providing both clinicians and patients better information on risks and benefits of treatments, including comparative effectiveness of treatments. So, there is a lot behind these bullets, and I would be happy to delve further into it during the question and answer session.

The important thing right now is for you to understand that the Commission is unanimous in believing that these are the sort of steps necessary for Medicare to improve value and efficiency in health care delivery.

The Commission is also unanimous in believing that this value and efficiency agenda is urgent and requires a much, much larger investment in CMS's capability to develop, implement, and refine payment systems.

CMS has important projects under way in this regard, some at the specific request of the Congress, but frankly the process is far, far too slow because we are not investing adequately in the improvement effort.

Now let me turn to the next bullet, the second bullet of the four dimensions of the SGR problem, and that is "Encouraging Fiscal Discipline in Policy Making." Well, if expenditure targets, by themselves, do not establish proper incentives for efficiency, what are they good for? What role could they play in the system?

Some Commissioners—and this is one of the issues where we are not in unanimous agreement—believe expenditure targets are useful in encouraging fiscal discipline in the policy-making process. So they are not useful in changing behavior of providers in a constructive way.

To be real blunt about it, they are useful in disciplining the Congressional process and the executive branch process of setting policy and budgets. To be specific and blunt, some Commissioners believe that expenditure targets make it more difficult to grant large rate increases to providers. Moreover, they may create the political leverage to force providers to accept reforms that they might otherwise resist.

While acknowledging these potential benefits, the other Commissioners who do not like expenditure targets believe that these benefits would come at too high a price.

Now let me go to the third of the four dimensions of the SGR problem, "Increasing Equity Among Regions and Providers." This is another area where we have widespread agreement within the Commission, and that is on the point that the existing SGR is highly inequitable in very important respects.

Let me give a few examples of that. If the target under the SGR is exceeded, all physicians are punished equally regardless of their individual performance. In addition, all regions of the country are treated equally, even though there is abundant evidence that health care delivery is more efficient in some parts of the country than others. As you know, there is more than a 2-fold difference in per capita spending at the State level.

Finally, the SGR is inequitable in that it targets only physicians, when in fact, from the Commission's perspective, we have not just a physician cost problem in Medicare, we have a total cost problem in Medicare that includes hospitals and post-acute providers, and everybody else in the system.

So if Congress elects to retain an expenditure target, we believe it would be both fairer and more effective to apply that target to total Medicare costs, not just physician costs, to apply greater pressure in high-cost regions of the country than low-cost regions, since they are the ones contributing more to the overall cost problem, and, in addition, it would be important to allow an opportunity for groups of providers—voluntary groups of providers—to band together in what we refer to as Accountable Care Organizations. Those groups of providers would then be entitled to a separate assessment of their performance relative to the targets established by the Congress.

Make no mistake: making an expenditure target system more equitable—and it would never be wholly equitable—is not an easy task. It would take time—and by "time" I am talking years, not a few months—years of effort, patients' determination, and investment in systems, information systems in particular, to guide the workings of the system. Without tying patients' determination and investment, the risk of failure and unintended consequences will increase dramatically.

So why make these investments? Why run the risk? Well, the proponents within the Commission of expenditure targets believe that Medicare's cost problems threaten not only the Federal budget, but also the entire health care system by reinforcing a style of health care that is increasingly unaffordable to Americans.

The last of the four dimensions.

The CHAIRMAN. You will need to wrap it up a little bit here.

Mr. HACKBARTH. I am at the last part.

The CHAIRMAN. Thank you.

Mr. HACKBARTH. And I appreciate your forbearance, Senator.

So the last part of this challenge, as you mentioned, is the budgetary impact of changing the SGR. I know this is where you most wish we had an easy answer for you, but, in fact, I do not.

I would say, however, that in our March report which we have sent you today, there are a number of proposals that could substantially reduce Medicare expenditures over the long run, and we would ask you to give serious consideration to those proposals.

Thank you very much.

The CHAIRMAN. Thank you very, very much.

[The prepared statement of Mr. Hackbarth appears in the appendix.]

The CHAIRMAN. I will now turn to Dr. Peter Orszag.

STATEMENT OF PETER R. ORSZAG, Ph.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. ORSZAG. Thank you very much, Mr. Chairman, Senator Grassley, and members of the committee.

My testimony this morning makes four points. First, the Sustainable Growth Rate method entails a target level of expenditures and a method for adjusting physician payment rates over time in an attempt to bring expenditures in line with the targets.

The first chart that I have shows that, because of relatively rapid growth in covered expenditures since 1997, spending covered by the SGR method has been above the targets established by the formula since 2002. You can see that in the solid blue line which is above the dotted blue line beneath it.

In 2006, expenditures covered under the SGR method——

The CHAIRMAN. And I might add, you have copies here, right?

Dr. ORSZAG. Yes.

The CHAIRMAN. Slides here. We all have the same slides, right?

Dr. ORSZAG. They are the same slides.

In 2006, expenditures counted under the SGR method totaled $95 billion, which was $13 billion more than the $81.7 billion expenditure target for that year.

There is also a cumulative target. Total spending since the SGR method was put in place in 1997 now stands at about $43 billion above the system's cumulative target. You can see that in the bottom solid line, which is, for 2006, above $40 billion.

As a result of these expenditures being above the targets, the SGR mechanism, if implemented as currently specified, will substantially reduce payment rates for physician services over the next several years.

In particular, CBO estimates that fees for physician services under the SGR will be reduced by about 10 percent in 2008, and around 5 percent annually for at least several years after that.

You can see that occurring because the top blue line falls beneath the dotted line at the top. Similarly, the cumulative spending falls back towards zero, which is the whole point of the SGR mechanism.

If fully implemented, payment rates could decline by a total of around 40 percent in nominal terms by 2015 if physicians continue to provide services at the current rate, and by much more than that in real or inflation-adjusted terms.

Second, legislation has prevented the reductions called for by the SGR mechanism from taking effect in recent years, and the Congress may choose to override the SGR mechanism again or may choose to change or replace it in the future. However, doing so will entail budgetary costs.

My testimony provides figures on the budgetary implications of different examples of changing the SGR mechanism. For example, one policy change would override the scheduled reduction for 2008

and hold overall payment rates under the physician fee schedule constant.

In 2009 and subsequent years, payment rates would be determined by the SGR formula, under which the maximum adjustment factor of –7 percent would apply. According to CBO's estimates, this option would increase net Federal outlays by $34 billion over the next 10 years.

As another example, and perhaps underscoring the scale and magnitude of the issue involved here, repealing the SGR mechanism—this is my next slide—and allowing updates in line with the Medicare Economic Index each year would increase expenditures by an estimated $262 billion over the next 10 years.

Furthermore, that change would increase Part B premiums and other expenditures for beneficiaries by about $70 billion, which is netted out of the $262 billion. So in other words, if you wanted to hold beneficiaries harmless from the increase in payment rates for physicians, the total cost would be something more like $330 billion over the next 10 years.

The third point in my testimony is that the SGR issue provides an important illustration of the powerful role played by incentives in the health sector. Changes in fees will affect the behavior of physicians. For example, evidence suggests that fee reductions would result in a partially offsetting increase in the volume and intensity of services provided by physicians.

Another behavioral response is that, especially if the large reductions in fees called for under the SGR mechanism were fully implemented, it would be very likely that physicians would impair access to Medicare Part B beneficiaries.

Finally, and perhaps most fundamentally, the task of setting payment rates for Medicare services must be addressed in the context of challenging long-run budgetary trends, my final chart.

Policymakers face both a challenge and an opportunity in addressing projected health care cost growth. The challenge is that, over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private sector health markets.

Many analysts, therefore, believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing cost growth in the health sector as a whole.

The opportunity is that a variety of evidence suggests the possibility of constraining health costs without adverse health consequences. Moving the Nation toward capturing this opportunity is essential to putting the country on a sound long-term fiscal path. It is the central long-term fiscal problem facing the United States.

In that context, it seems particularly useful to examine options for using the payment system to encourage the health system to deliver high value and cost-effective care. Former CMS Administrator Mark McClellan refers to this as moving from a fee-for-service system to a fee-for-value one.

Systems for shifting incentives toward higher-value care will likely require two changes to the underlying health infrastructure. The first is an information infrastructure to collect data on patients' conditions, the services ordered by physicians, and health

outcomes, and then to distribute information back to individual doctors or groups, basically a significant investment in health information technology.

The second is an adequately funded institution, whether inside the government or outside it, to analyze the data, evaluate comparative effectiveness, and perhaps design and implement payment systems that reward the more efficient practice of medicine.

The Congressional Budget Office will be examining both of these potential steps in future reports. Even with these systems in place, shifting provider incentives will necessarily be an iterative process in which both innovative medical interventions and payment mechanisms are tried, evaluated, and recalibrated.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much. That is very helpful.

[The prepared statement of Dr. Orszag appears in the appendix.]

The CHAIRMAN. Dr. Wilson?

STATEMENT OF CECIL B. WILSON, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, WINTER PARK, FL

Dr. WILSON. Thank you, Mr. Chairman.

My name is Cecil Wilson. I am chair of the board of trustees of the American Medical Association. I am also an internist from Winter Park, FL.

The AMA wants to thank Chairman Baucus, Senator Grassley, and members of the committee for your efforts under H.R. 6111, the Tax Relief and Health Care Act of 2006, to stop the 5-percent Medicare physician pay cut in 2007 and to allocate $1.35 billion to help offset the projected 10-percent cut in 2008.

However, the Medicare physician payment system is broken. Over the last 6 years, as you have heard, MedPAC has recommended physician payment updates consistent with increased practice costs, while Congress has not adopted those recommendations. The result has been that payment rates have fallen well below medical inflation.

Since 2002, the physician community has had to work with Congress each year to achieve 11th hour interventions to ward off steep payment cuts and preserve patients' access to care.

As long as spending targets remain in place, this annual cycle has no end in sight. This is no way to do business and no way to treat Medicare patients. It is time to replace the underlying cause, the SGR, and protect the Medicare program, especially as the baby boomers begin enrolling in 2010.

MedPAC recommends that Congress provide a 1.7-percent payment update for 2008. We strongly agree. MedPAC has also identified SGR alternatives. One is to repeal the SGR, along with adopting methods to assure appropriate use of service. The AMA agrees.

In fact, this is a first priority on joint recommendations that the AMA has developed, along with 77 organizations representing physician specialties and other health professionals.

These recommendations, attached to our written testimony, also provide mechanisms by which the medical profession would work to assure appropriate use of medical care. This would include analyzing utilization and quality by condition, type of service, episodes

of illness, region, and specialty. We are committed to working with Congress, CMS, and MedPAC to develop these mechanisms.

As a second alternative, MedPAC suggests expanding the spending target to all Medicare services and providers. The AMA does not support an expanded target. No amount of tinkering can fix what is broken beyond repair.

In fact, MedPAC previously concluded that expanding the SGR to other Part B providers is unworkable and would extend SGR-driven pay cuts. In addition, spending targets are incompatible with physician adoption of health information technology and quality initiatives.

The reason is, quality initiatives often encourage greater utilization of physician care, including aggressive strategies to manage chronic diseases that increase physician visits, imaging, lab tests, and drug therapies. This can reduce more expensive hospital admissions, but it increases spending under the SGR, leading to additional payment cuts.

Payment cuts make it impossible for physicians to make the significant financial investment needed for health information technology and quality initiatives. The SGR has trapped physicians and policymakers in a vicious cycle.

Now, spending targets also presume that physicians alone control the utilization of Part B health care services. The reality is, many other factors contribute to volume growth for Part B.

These include the increased prevalence of chronic conditions, government benefit expansions, new life-saving technologies, and an aging population. Because of this, spending targets are ineffective.

Finally, I would like to respond to concerns that Medicare physician payments will increase Part B beneficiary premiums. Premium increases are due, in part, to increases in payment for physician services, but also for other services covered by Part B, including, for example, hospital outpatient services, Medicare Advantage plans, and other providers; in fact, spending for physician services accounted for only 14 percent of the 2007 premium increases.

The AMA asks that Congress ensure that physicians are treated like hospitals and other providers by repealing the SGR and enacting a payment system that provides updates to keep pace with increases in medical practice costs. We, in turn, are committed to helping to assure appropriate use of services, and thank you for the opportunity of being here today.

The CHAIRMAN. Dr. Wilson, thank you very much.

[The prepared statement of Dr. Wilson appears in the appendix.]

The CHAIRMAN. Dr. Thames?

STATEMENT OF T. BYRON THAMES, M.D., MEMBER, AARP BOARD OF DIRECTORS, ORLANDO, FL

Dr. THAMES. Mr. Chairman, members of the committee, I am Dr. Byron Thames of the AARP's board of directors. Thank you for inviting AARP to testify today.

AARP believes that the time has come to move Medicare towards a payment system that encourages physicians to provide greater value for the health care dollar. AARP recently conducted a survey asking older Americans—current, former, and future Medicare beneficiaries—about their experience with physicians.

The vast majority of those surveyed report good access to, and high level of satisfaction with, their physicians. But for many, the cost of care remains a concern. The AARP members surveyed are among the over 43 million Americans who rely on Medicare for health care coverage. Physicians are central to the delivery of that health care.

While we believe physicians who treat Medicare patients should be paid fairly, we have learned from our members the program must be affordable as well. Determining how to balance these two needs is a complex, yet critical, policy problem that must be solved for the Medicare program to remain strong for future generations.

The Sustainable Growth Rate system, which has been widely recognized as flawed, does not distinguish between doctors who provide Medicare beneficiaries with high-quality care and those who provide unnecessary or inappropriate services.

Moreover, the SGR has not been effective at controlling the volume or intensity of services, leading to higher Medicare spending and greater out-of-pocket costs for beneficiaries.

The monthly Medicare Part B premium, set at 25 percent of Part B spending, has doubled since 2000. Beneficiaries also face increased cost-sharing obligations—higher deductibles—when Part B expenditures rise. There does not seem to be an end in sight to these out-of-pocket increases. Using existing SGR methodology, physician fees are expected to be reduced each year, at least until 2012.

Under this scenario, we can expect to continue the now-annual cycle of physician groups lobbying Congress to avoid payment cuts, doctors threatening to stop taking Medicare patients, and Congress overriding the SGR at the last minute.

We must find a better approach. AARP believes that, ultimately, the SGR should be replaced with a system that encourages physicians to provide beneficiaries in the Medicare program with greater value for the health care dollar.

Medicare beneficiaries need, and expect their doctors to provide, effective treatment. Payment incentives should encourage high quality, not unnecessary quantity. A truly sustainable payment system would be built on a foundation that emphasizes four key elements: (1) information technology; (2) greater use of comparative effectiveness; (3) performance measurement, including physician resource use; and, (4) enhanced care coordination.

My written statement details each of these. But before any changes to the SGR are made, there are a number of factors to consider. First, ultimately repealing the SGR would be, and will be, quite costly. A transition to a value-based purchasing framework must not be financed at beneficiary expense.

Second, we need to make sure beneficiaries are protected from extraordinary out-of-pocket expenses as the system is reformed. One such protection could be a cap on Part B premium increases. Another potential option is to limit total Part B out-of-pocket costs.

Third, elimination of the SGR cannot be viewed as carte blanche for physicians to maximize revenues through uncontrolled volume. Rather, a new payment system should be designed to encourage appropriate care.

Congress cannot continue to avoid the current problem in the Part B payment system. Each year we wait, the problem only gets worse. We believe the time to act is now. AARP stands ready to work with Congress and the physician community to develop a workable solution.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Thames appears in the appendix.]

The CHAIRMAN. Thank you all very much.

I would like to turn to Senator Grassley, who unfortunately was detained at the beginning. He would like to make an opening statement.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Yes. What I want to do here, Mr. Chairman, is I want to put my statement in the record right after your statement, and I just want to highlight some points.

It is obvious from what everybody said here today that we are working with a formula that is fundamentally flawed and obviously is not working the way it was intended to do. Maybe we did not have an understanding of that 20 years ago, but we sure know it now.

One of the key questions being examined today already is to improve value in Medicare and to reward that higher quality and more efficient care. In order to do this, we have to do away with a system that rewards over-utilization and inefficiency.

That is how we are paying people today. But this method of spending has little bearing on quality, even though you and I have been working in that direction with people in the previous Congress leading the Ways and Means Committee. We are just barely making baby steps that might lead us to that point, and we have confidence it will, but we may come to the conclusion that it is taking an awful long time, too.

There is no doubt that most physicians care deeply about the quality of care that they provide their patients, but the system does not have the right incentives that are going to foster improvement of care, so we need to change the equation and identify better ways.

One way that Senator Baucus and I have worked on in the last Congress was the Medicare Value Purchasing Act, and obviously it was just introduced and has not moved. I look forward to talking to the Chairman about a possible reintroduction of that bill.

So today in this hearing under new leadership, we face the challenge of developing that long-term solution to the physician payment formula. We have to ensure that physicians and other health care providers can afford to practice medicine at the same time we are trying to make these changes.

But we also have to preserve Medicare beneficiaries' access to physicians. Now, in urban areas that may not be a major problem, but in Montana—and maybe more so in Montana than even in Iowa—it is a very major problem. And, of course, to do all of this is a very tall order that the Chairman is taking on, but it is something we have to do.

One point that I want to make that just came to my mind was not in my printed statement. Now, you folks may consider all of Iowa rural, even including Des Moines of 250,000 people, but let me tell you, when you get out into the county seat towns and I have my town meetings, doctors are so busy, they do not come to every meeting.

But when doctors do show up and they talk about the SGR, you really feel a morale problem among doctors in rural areas. You even feel it more strongly from the spouses who come along with their husbands and express it. I think we have to keep that in mind if we are going to have quality health care delivery in rural America, primarily.

Thank you.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Thank you very much, Senator.

I would like to do a couple of things here. First, I want to just establish how deep of a hole we are in with the SGR and how intractable it really is.

Dr. Orszag, if you could just give us a sense of what the formula is doing to the budget and, therefore, the problems that we have facing us with respect to it.

Dr. ORSZAG. Well, again, one metric for that is to look at what would happen if you repealed the SGR mechanism, and over the next 10 years that would entail another $262 billion in expenditures for the Federal Government, plus another $70 billion in higher costs for Part B beneficiaries. If you held the Part B beneficiaries harmless from that increase, the total net cost to the Federal Government would be $330 billion.

The CHAIRMAN. So the formula is presenting a great problem for us.

Dr. ORSZAG. That is a significant expenditure, yes.

The CHAIRMAN. Right.

I would like to just ask all of you if you agree with the basic view that, if we are going to address health care costs—we are now talking about physicians, but it probably is true for other health care costs—we have to get at the underlying reason why Medicare costs are going up so much, the underlying reason why Medicaid costs, health care costs, both public and private sector, are going up so much.

Unless somebody indicates to the contrary, I am going to assume that you all agree that that is probably the fundamental direction that we should be pursuing. Is that correct? Dr. Wilson, do you agree?

Dr. WILSON. Absolutely. One of the problems with the SGR, it is the meat axe, it is not the surgeon's scalpel. As you have heard, it does not tell us how much of that volume is appropriate and how much of it is inappropriate, and that is where we need to look.

The CHAIRMAN. Right. Right.

Now, the next question. If we all agree generally on that point, the next question is, obviously, what do we do about it? Which measures are going to be most effective in the near term and which measures might be more effective in the long term? Some have sug-

gested health information technology, for example, and comparative evidence.

Let us go to pay-for-performance, for example. I would like to kind of go down the table here and have each of you give the measures you think that we should be pursuing here that you think are most efficient to get at underlying health care costs.

Mr. HACKBARTH. The crux of the problem is the incentives in the fee-for-service payment system. So if you want to change how the system works, the mix of care provided, you have to begin changing fee-for-service payments. There are a lot of different components for doing that, but let me just highlight a couple.

The CHAIRMAN. We do not have a lot of time here. Just hit the highlights.

Mr. HACKBARTH. Just to give one example.

The CHAIRMAN. Sure.

Mr. HACKBARTH. One example is to pay physicians differently to better reward primary care and better reward care coordination, especially for patients with expensive illnesses.

The CHAIRMAN. But how do we get there when the specialty doctors do not like that? Basically, they do not want to give up what they have.

Mr. HACKBARTH. Well, I thought the original question is, what needs to be done.

The CHAIRMAN. Right. [Laughter.]

Mr. HACKBARTH. None of these changes are going to be easy, either from a technical standpoint or a political standpoint. The alternative is the path that we are on. A system that does not work to change behavior in a constructive way ultimately will threaten access to Medicare beneficiaries and blow a hole in the Federal budget.

The CHAIRMAN. How do we address over-utilization?

Mr. HACKBARTH. Well, there are multiple ways, but an example is effective primary care and care coordination for patients with serious illness. A lot of money goes to a small number of Medicare beneficiaries with multiple chronic illnesses.

The evidence shows that many of those patients are receiving more services than they need, in fact, in some cases so many services that they are harmful.

The CHAIRMAN. That is correct. So what do we do about that?

Mr. HACKBARTH. Change the payment system.

The CHAIRMAN. How?

Mr. HACKBARTH. There are a variety of different steps that we have discussed, and will be discussing in the future, that would change payment, increase payment for primary care, and a number of different alternatives we are looking at for encouraging and rewarding care coordination.

The CHAIRMAN. Thank you.

Dr. Orszag?

Dr. ORSZAG. I think I have two basic messages for you. First, in health care we get what we provide incentives for. So we currently provide lots of incentives for advanced technologies and high-end treatments, and we get a lot of that. We provide very little incentive for preventative medicine, and we get very little of that. So that is the first theme.

The second theme is, given the scale of the problems that we face, we need to be trying lots of different things and recalibrating all the time, so we need to get into a mode of experimenting, trying, and readjusting.

Again, I would come back to two steps that I think are necessary, but not sufficient. We do not have the evidence base yet across a variety of treatment practices and technologies to know exactly what is over-utilization in all cases and what is appropriate care. We need to build that evidence base before you can design a broader system for altering incentives.

So I think, again, the two key steps are, we need some institution, whether inside the government or outside the government, like the National Institute for Clinical Excellence in the U.K., that examines the data on comparative effectiveness and that is accepted by the medical profession as defining best practices.

Second, we need an HIT backbone in order to provide the necessary information to that body to conduct those kind of analyses and then to push information back to physicians, doctors, and other providers. If those two steps were taken, you would at least have put in place an infrastructure to start making the hard decisions that will have to be made.

The CHAIRMAN. I appreciate that. My time has expired, but I am going to come back to this theme the next round and ask all of you the degree to which you agree or disagree with Dr. Orszag's basic approach.

Senator Grassley?

Senator GRASSLEY. Thank you very much.

I want to make clear something maybe I left out when I talked about morale among doctors in rural areas. I think it comes, as I hear it expressed to me, it is not just the level of payment or a formula that probably does not make sense. It is mostly related to the uncertainty of it as much as it is the formula itself.

It is also related to the fact that all this time, costs are going up for doctors at the same time that they might be taking a cut, at the same time that they do not know whether they are going to get an increase. That is the morale problem that I was speaking of.

Now, unrelated to that, I want to get to Dr. Wilson about one of the fundamental recommendations of MedPAC. It is for a differential update to providers, and that would be based upon quality of care.

Does the AMA support a physician payment system that will pay some physicians more and some physicians less based upon quality of care delivered? Then would Dr. Thames listen so I can get your reaction?

Dr. WILSON. Thank you, Senator. I think the important thing here is to say that the system we have is not working, and we are in agreement on that. The other important thing to say is that we believe that we should provide the best care possible.

I would also say to you that when I get up in the morning and go to serve patients, I want to do the best job that I can. The best way that I can do that is to know what is the best thing to do.

So the quality measures that we have been involved with for the past 7 years are an effort to look at the latest in terms of science and then to educate physicians about that.

I think the jury is still out about whether an incentive for doing certain things like that is going to make a difference, and I think we do not know that.

Senator GRASSLEY. All right. So then your answer is that you cannot, right now, say whether you are willing to take a position on more pay for some doctors, less pay for some other doctors, based upon quality. You just do not know at this point.

Dr. WILSON. That is correct.

Senator GRASSLEY. Dr. Thames? Maybe you cannot comment on it since he did not really take a position, but I still would invite your comment.

Dr. THAMES. Sir, I was a practicing physician for 41 years doing family practice, so I am very concerned about what is going to happen. I would say I fully support the AARP position that we should move towards evidence-based medicine and pay for quality performance, and pay less for people who do not provide quality performance.

We believe that you made a great step last time in paying for reporting so that we can develop an accurate assessment of what is quality care that we ought to be paying for.

We believe that the study of the outliers mentioned by MedPAC is only one way of looking at where people are getting care that seems to be as good for life expectancy, hospital admissions, and so forth, for much less cost in some areas of the country and much less frequency of visits, much less medication, whereas those costs, for instance, in Miami, FL—and remember, I am from Orlando, FL so I know how it is in Miami and Florida as a whole—where those costs for the same kinds of services are considerably greater and the amount of services is greater.

Senator GRASSLEY. And I think you are very clear that you do think that there would be a good system if there were some doctors paid more, some less, based upon quality.

Dr. THAMES. Yes, sir.

Senator GRASSLEY. All right.

Now, if I could go to Dr. Orszag. This is in regard to the same outlier issues that have been brought up. CMS announced that it would target outliers to determine if there was fraud or abuse.

So my question to you, too, do you think that this outlier and auditing system would alter physicians' behavior? If so—and this is probably more important than the first part of the question—would you expect that you could measure savings for people like Senator Baucus and me to figure out just exactly what things cost and how much savings we have, et cetera? Go ahead.

Dr. ORSZAG. Again, there is significant evidence of very substantial variation in costs per beneficiary, for example, across different regions and across different providers within the Medicare system. I think that financial incentives do affect behavior, so changing financial incentives will affect behavior.

For example, if you move towards paying for quality or paying for value rather than just fee-for-service, whether the net effect is a reduction in cost or an improvement in quality is a little bit harder to tell, but either way you are getting a better return on your taxpayer dollars. So the sign of the cost effect is more ambiguous than an improvement in efficiency per dollar.

Senator GRASSLEY. All right.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Thank all of you. Mr. Hackbarth, we are proud that you are from Oregon and you know a lot about our predicament, where we have good-quality medicine and we, in effect, get penalized for it. We are anxious to work with you on your recommendations there.

I want to talk about what largely has been missed this morning, and that is preventive medicine. If you are going to keep seniors out of hospitals, then you hold costs down. It seems to me you do that by rewarding prevention.

The private sector is doing this like crazy, companies like Safeway saying their premiums are going down 12 percent, largely because of prevention. Somehow, Medicare has missed the whole prevention revolution, something I am trying to change.

You may know, in my legislation, Mr. Hackbarth, I have given the Secretary of Health and Human Services the legal authority to discount the outpatient premiums for seniors who lower blood pressure, cholesterol, engage in good health practices.

What incentives have you all looked at for what I think is at the heart of this debate: rewarding good behavior as a way to hold down health care costs?

Mr. HACKBARTH. We would certainly agree that preventive services of the sort that you mentioned make common sense and they tend to be relatively low-cost interventions that can avoid much more costly problems later on.

We have not looked at specific mechanisms to finance and reward that behavior. Our focus has been a little further upstream, if you will, in looking at care, for example, for people who already have chronic illnesses, and how you assure that those illnesses do not get worse, that they do not experience unnecessary complications and the like.

Senator WYDEN. So why not do what the private sector is doing, which is to get at it earlier? I mean, it seems to me, so much of what the Federal Government does lags behind the revolution in the private sector.

Mr. HACKBARTH. Yes.

Senator WYDEN. What I am talking about costs no money. I am talking about saying, under Part B of Medicare, this fast-growing portion, simply give the Secretary the legal authority to say that, when it is cost effective, it can provide discounts for the behaviors that we know keep seniors out of the hospital.

Mr. HACKBARTH. Yes. We simply have not looked at that particular proposal. I am not saying that we would be opposed to it, by any stretch. We just have not examined it and made a specific recommendation on that. The underlying argument makes a lot of sense.

Senator WYDEN. What is the Commission looking at in terms of rewards, not just in prevention, but also in chronic care? Because 5 percent of the Medicare population, as we all know, consumes 50 percent of the health care dollar.

It seems to me, if we do nothing else but try to reward on the preventive side and then make better use of the dollars on the chronic care side, we are a long way to being able to make progress here.

Mr. HACKBARTH. Yes.

Senator WYDEN. What incentives are being examined on the chronic care side?

Mr. HACKBARTH. Well, we think that you would need a multipart approach to improving the incentives that are currently in the system. One part of that approach would be to improve payment for primary care services, because good primary care has been shown to be critical in appropriate care for people with chronic illnesses, both in terms of improving quality and reducing cost.

Within that general heading of improving payment for primary care, there are a variety of potential approaches that we have looked at.

Senator WYDEN. How about incentivizing what is essentially called the "health home," where a physician in the chronic care setting would handle the various services that a person needs?

Mr. HACKBARTH. Yes. In essence, what that idea talks about is paying a lump sum to a primary care physician to assume responsibility, clinical responsibility, for ongoing management. There is a lot about that idea that appeals to us; it is a concept that appeals to us.

The chief question that we have at this point is how to structure it in as efficient a way as possible. That sort of ongoing management requires a couple of additional resources that many physicians in small practice do not have. One is non-physician staff to do the ongoing interaction with patients, education of patients and the like.

A second type of resource is information technology support. What we want to come up with is a payment system that supports physicians in building in those resources as efficiently as possible to minimize the cost for the Medicare program, and that is what we are examining.

Senator WYDEN. Keep your home in Bend. We are glad to have you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

Senator Roberts?

Senator ROBERTS. Thank you very much, Mr. Chairman. Thank you for holding the hearing. Thank you to all the panelists.

I just want to let you know, last week I was traveling all across Kansas, and I was meeting with many of our community hospitals and local doctors. Their message was loud and clear; mine is loud and clear; I think everybody on the committee's is loud and clear: fix the Medicare payment formula so our doctors can stop really worrying about the uncertainty of the payments. You have already testified to that. That is obvious.

Instead, focus on giving patients the care they need and deserve. A 10-percent cut, if we do not do anything this year, 5.7 on hospitals. That is simply not acceptable.

So I noted in *CQ*, Mr. Chairman, you indicated that, despite our best efforts, you do not think MedPAC has enough fleshed out

ideas on how we get this done. And I am not picking at MedPAC, because it is a very, very difficult assignment or challenge.

But I also noticed that on page 2—all of a sudden I am Paul Harvey—one option would be to "scrap the formula and begin working toward a new payment system based on doctors' quality of care, how well they coordinate care with other providers, and how efficiently they use resources such as lab tests and imaging scans.

Second, another option would be to keep the framework of the existing formula, but make the national measurement of physician costs and payments more regionally based.

I am a little leery—actually, I am frightened to death—of the regional-based business in regards to the rural health care delivery system after all of the problems that we have been through, and being under-served areas. So mark me down, Mr. Chairman, as being an advocate of the first alternative, if we can get there from here.

Let me get to the questions, if I can. Mr. Hackbarth, your MedPAC outfit, or your posse that you ride with— [Laughter.] We need an appropriate balance between the urban and the rural interests. All right. Now, we have Witchita, Topeka, Oletha, other places that are urban. We have a very fine health care system.

But you are 17:1. You have 17 people on one side, on the urban side, one from Montana. Seventeen to one. That is like a game pitched by Jim Bunning. [Laughter.] He was on the 17 side.

I would like to know how seriously MedPAC considered the difficulties that we face in our rural areas. And by the way, if we are going to have CMS be the criteria on the objectivity, on the quality of care, I have a little concern about that. That used to be HCFA, then we changed the acronym to make it sound better. They do not read all of the regulations and paperwork, they weigh them.

So we are going to add in more criteria to determine whether a doctor out in Dodge City, KS, America is up to a certain quality, when we cannot find doctors? Well, we can find them in Dodge City, but on out, I am not too sure.

Senator Salazar knows exactly what I am talking about. So, I have some real problems with that. But basically if you are going to say we are going to measure the criteria on how long people live, just move to the rural areas. We live longer.

Now, I just made a speech. My question to you was, basically, how much attention did you pay—I am sure it is a lot—to our senior population in our rural areas with MedPAC, with a 17:1 ratio? I am sort of picking on you.

Mr. HACKBARTH. Yes. The composition of the posse. Right?

Senator ROBERTS. Right.

Mr. HACKBARTH. I have been Chairman of MedPAC now for over 6 years.

Senator ROBERTS. And we thank you for your service.

Mr. HACKBARTH. Yes. Rural issues have been prominent in the MedPAC agenda over that 6-year period. We have a number of MedPAC commissioners who have extensive, longstanding interest and experience with rural issues. You mentioned one, Dr. Nick Walter from Montana.

In addition to Dr. Walter, Dr. Karen Borman from Mississippi. Senator Dave Durenberger from Minnesota, who has a very deep

interest in rural health care in the upper Midwest region. Sheila Burke, Senator Dole's former chief of staff.

Senator ROBERTS. I am well-acquainted with Sheila. Right.

Mr. HACKBARTH. We have spent a lot of time in your home State of Kansas on these issues. So I do not think it is fair to say that we have one commissioner——

Senator ROBERTS. I will accept that. I need to get one more real quick question in on primary care. I am out of time. I am down to 4 seconds. He gets just meaner than a snake. [Laughter.] He is from Montana and they have big snakes. All right.

The CHAIRMAN. Senator Roberts has also mastered the art of giving his speech and, when there is only about 10 seconds left, asking the questions.

Senator ROBERTS. Right. [Laughter.] It comes with the territory in our under-served area, sir.

The CHAIRMAN. Right.

Senator ROBERTS. Which you so ably represent, and that of the Ranking Member. And Senator Hatch as well.

The CHAIRMAN. Senator, take all of your time.

Senator ROBERTS. All right. Thank you. [Laughter.]

How are we going to give incentives to primary care? What was the word you used? It was a big word. But are we going to pay primary care doctors an incentive to be primary care? Because we have a lot of young people coming into the business, according to everybody that I talk to in Kansas, getting into the specialties, and that is nothing new, but very few into primary care.

You do not have that Grand Central Station, if that is the word for it, or that one person who knows all of the variables of that individual's maladies that could be very, very difficult.

My mother died because of this, and I have a lot of feeling about it, and I blame myself for that because I did not really understand what was going on. So how can we do that? I know there is no one-word answer to that.

Dr. Thames, for 41 years. Bless you, sir, for your service. If you have any idea, how can we incentivize more primary care doctors? I know there is not any one answer, but can you just——

Dr. THAMES. You are correct, there is no one. But there is no question that the way to incentivize them is to find some way to pay them for the services they provide.

If you have a medical home, whether it is a family physician or general internist providing that medical home, and you pay for them to coordinate the services—we talk about coordinating services—and prevent these interactions that come when we don't do that, and the poorer outcomes from chronic conditions because we have a lot of physicians and no one looking at them, if you pay them, whether it is slightly more to see them or on a monthly basis to do that, you will attract more people to the specialty because they will get paid better, and you will certainly want more people to provide that service for your folks.

Senator ROBERTS. Well, it is a labor of good love, and we thank you for your service.

Thank you for your patience, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman. Thank you again for an excellent hearing, to each of you.

I would just say to my friend from Kansas—and I share his feeling about this—that one of the important ways at least to start to support primary care physicians is to make sure they do not get a 10-percent cut next year, which is why I think this hearing is so important.

Generally, I am hearing that SGR does not work. I share that, as Dr. Wilson knows, having introduced legislation last year that would eliminate the SGR and involve more physicians in what should replace it.

A couple of questions, though. One, in looking at the numbers, when we look at, Dr. Orszag, the numbers that you put up about the cost of eliminating the SGR, one of the areas of interest to many of us in Congress, and what we have heard from physicians, is that including Part B drugs is really, first of all, not fair because it is a part that is not controlled by physicians and it adds tremendously to the costs, and would add to the cost of the repeal.

So I am wondering, when you looked at this, do you know what it would be if we took out the costs of the Part B drugs and instead had the SGR replaced with an MEI update?

Dr. ORSZAG. Senator, the inclusion of Part B drugs, especially because there has been rapid growth in that component since 1997, does have a very significant effect on the projections, and it is assumed in the figures I gave you that those drugs continue to be included in the formula. We can get you information about the estimated impact from taking them out, but I would say it is significant.

Senator STABENOW. I would appreciate that.

Mr. Chairman, I think that is an area to really look at. I would ask that we look at the formula which now includes drugs as a part of it, when it is really not a measurement of, in my opinion, the physician piece. It is, the cost of drugs that have gone up, as we know, and it is now driving a part of that.

My larger question raises something you have all been talking about as well as a solution, which is health information technology, which again, I share. I was very interested that each of you talked in some way about that.

Dr. Orszag, you talked about the fact that we need an information system in place and that we need incentives to do that. Of course, if we are looking at evidence-based information, as you talked about, Dr. Thames, it seems to me we have to start by gathering the information in the most cost-effective way.

One of the challenges I see, and I guess I would welcome any of you responding in terms of what you believe we should be doing to incentivize health IT, because one of the challenges is, we say to physicians, we are cutting your payments or we are freezing your payments and, by the way, go out and invest in hardware, software, and train people for health information technology, when most of the savings ends up with us in the Federal Government from Medicare and Medicaid, and so on, as well as the quality, dramatically increasing the quality for patients in terms of sharing information and more up-to-date information, and so on.

But how do we get there? How do we incentive those who need to be doing this so we can reap that and we can measure? If we are going to have pay-for-performance, it seems to me we need to start with a pay-for-use, or incentives-for-use so we can get the information, so we can then do the evidence-based quality analysis. We are stuck at the moment because we do not have the health IT and the information system to be able to do that.

Yes?

Dr. ORSZAG. Senator, I think you put your finger on the most important thing, which is to reward the use of information technology. There is a ton of money in the American health care system. We find the money to invest in all sorts of new imaging equipment, tests, and all sorts of capital investments.

Why do people spend money on that stuff and not on clinical information technology? Because there is the return on the investment in the new scanner and there is not a direct return on investment in information technology. So we need to pay for performance, pay for the quality produced by information technology, and you will start to get more of it.

We think that is a far better approach than saying, well, let us just make grants to everybody to buy information technology. You will get lots of boxes in offices but not necessarily a lot of constructive use from what is in the boxes if you just give money. Reward the performance and that will encourage the investment.

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you very much.

Senator Bunning?

Senator BUNNING. Thank you, Mr. Chairman.

I thought Senator Wyden really hit the nail on the head: preventive medicine. In Kentucky, if we had a system where we could go into rural Kentucky with some kind of preventive medicine information, whether it be information technology that is able to keep up with that—we spend, as he said, 50 percent of our money with 5 percent of our recipients.

The SGR system is a non-working system, that is all there is to it. It does not work. I have tried since I got on this committee to include a permanent fix for SGR. There is no permanent fix because it is a broken system.

I would like to ask, we talk about things. I want to ask a question, because I do not have much time. I am very concerned about the increase in entitlement spending. We should not look at the physician payment issue in a vacuum.

In fact, the President's budget proposed reducing the Medicare growth rate from 6.5 to 5.6 percent over 5 years. For Medicaid, the growth rate is reduced from 7.3 to 7.1 percent. Everybody says, well, that is a cut. How important is it for us to consider overall Medicare reform—Medicare reform—including the physician payment issue, this year instead of putting it off to sometime down in the future?

Dr. WILSON. Senator, I would like to respond. The answer is, it is very important. We have been kicking this can down the road for the last 5 years. I think certainly this committee, and Congress, understands it is not going to get any easier.

Senator BUNNING. By 2012, it is down the road to the point where we cannot do it any more.

Dr. WILSON. Exactly. Yes. I did want to respond a little bit to the issue of prevention, primarily from the standpoint of early detection, because I can tell you, as an internist, a lot of my patients understand the value of increased activity and diet.

They also understand the value of early detection, so mammograms and immunizations. The test of whether they get those is not whether they know they ought to get them, it is whether they are covered. So the reality is that a lot of coverage decisions do make a difference in patients' behavior in some very important ways.

Senator BUNNING. Absolutely.

Dr. WILSON. I guess, maybe to extrapolate from that to say there are benefits there in terms of less hospitalizations. There are also benefits to society at large in terms of a healthier society. So I think, as we think about the cost of this, we need to sort of think about the bigger picture in terms of the value that we get.

Senator BUNNING. All right.

Several of you mentioned in your testimony that current physician formulas might actually encourage more spending by doctors as they increase the intensity and volume of services provided. Briefly, what are some of the ways we could avoid this in the future if we change the formulas? Go ahead.

Dr. THAMES. Well, I will take a shot at it, Senator.

Senator BUNNING. Go.

Dr. THAMES. I think one of the ways we can do that is to look at the best practices and evidence-based medicine. We are now working with the medical community to get those best practices and determine what ought to be done, let us say, for diabetes, hypertension, and other things.

Then we ought to be tracking those, as you are trying to do now with your reporting. Then we ought to be paying those people who follow those guidelines that are based on evidence-based medicine to show that they are cost-effective and do the tests.

We also know how many lab tests, and what kind, ought to be done. Those who are doing more of those should not be paid as well, and those who are not doing the ones that are necessary should not be paid as well.

Senator BUNNING. Well, I sincerely believe, if we can early on detect the costs as we go down the road—I can use my mom as an example, diabetic, discovered at age 81. That is the first time they discovered that she was diabetic. In 2 years, she was gone. But the fact of the matter is, she was reluctant to go see doctors. She hated to go see doctors. Maybe it was mistrust, or whatever it might be.

But early detection is a key to the cost factor. I would appreciate us doing something now rather than later. I think I even put it in a couple of bills, that we should stop kicking the can down the road.

Thank you for your time.

The CHAIRMAN. Thank you, Senator. That is very important. Thank you very much.

Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus and Senator Grassley, for your leadership on this very important issue. Thank you to the excellent panel for being here and sharing your thoughts with us on this very difficult and seemingly so complex and intractable problem.

The manner in which Medicare reimburses physicians and other medical providers has enormous implications on the access to, and delivery of, health care services to the beneficiaries of the program.

It is clear to me from listening to patients, doctors, and providers in Colorado, that the manner in which Medicare compensates physicians is, in fact, flawed.

The Sustainable Growth Rate fails to foster adequate health care delivery systems in rural towns and communities, fails to reward physicians who provide quality efficient care to its beneficiaries, fails to punish physicians who waste valuable resources and provide poor care, and fails to control the unprecedented program growth and spending that places a very significant burden on the American taxpayer.

Moreover, the SGR has seriously threatened beneficiary access to critical medical services by mandating significant annual physician payment cuts. The impact of the SGR's payment cuts on rural health care is particularly alarming to me, as it is to Senator Roberts, Senator Baucus, and others who have already spoken on this issue.

Approximately one in every four Medicare beneficiaries lives in rural America. Rural physicians serve a critical role in towns and communities in my State of Colorado, and across the Nation, where the nearest health care facility of providers may be 4, 5, 6, 7 hours away. In my State of Colorado, 15 counties out of 64 have two or fewer physicians providing patient care for the entire county.

Many rural physicians and providers have higher costs than physicians in urban areas and face significant challenges in recruiting staff and maintaining enough patients to break even. My point here is, there is a huge issue in terms of rural health care and the provision of Medicare services there.

I have a question. I do not want to use all my time in giving you a speech, so I have a question that is a follow-up to Senator Baucus's question. I will ask that you respond, and take 1 minute apiece.

First to Dr. Wilson, second to Dr. Thames, and then to Chairman Hackbarth. When Dr. Orszag was responding to Senator Baucus, he said there were two things that we could do to deal with overutilization of health care costs.

Dr. Orszag said we could do a National Institute for Clinical Excellence so we could start developing the database, and then invest in an IT database where we can develop the evidence that we need.

I would like each of your responses to that suggestion, because it seems to me that we need to start somewhere, and those are two suggestions that made sense to me.

Dr. WILSON. Well, thank you, Senator. What I would do is say that I agree that those are the things we need. I think the question is how to do those. I would just remind the committee from my testimony that the AMA, since 2000, along with over 100 specialties

in the country, has been developing state-of-the-art performance measurements.

[Audio interruption.]

Senator HATCH. So we spent an awful lot of money on this. So I guess what I am asking each of you here today, from 2001 to 2002, Medicare imaging services grew at 9.4 percent, and tests at 11 percent.

Now, within these two classes of services, the volume of nuclear medicine, CT scanning, MRIs, laboratory tests, and others, and minor procedures grew at 20 percent. Now, what do you believe accounts for the astonishing rate of growth of these services? Would you each give me your opinion of what the costs to society are from these frivolous medical liability suits?

We found that a high percentage of them were frivolous, in other words, suits that should never have been brought. This is something we are going to have to face sooner or later, and we are going to have to get both parties to face it.

But give me your opinion on both the high price of these nuclear medicine approaches and tests and what you think the impact of medical liability litigation adds to the high cost of medicine. I will start with you, Chairman Hackbarth, and go right across.

Mr. HACKBARTH. We have not looked specifically at the magnitude of the impact.

Senator HATCH. But you suspect that what I am saying is pretty accurate?

Mr. HACKBARTH. I have no doubt personally that it is a factor that influences how physicians make decisions, what they prescribe, and in particular, the type of tests.

Senator HATCH. But it is a cost factor as well. A huge cost factor.

Mr. HACKBARTH. It increases costs.

Senator HATCH. The reason we told doctors you have to do this defensive medicine, we told them, you want to have your history of that patient ruling out every possibility, even though you know that it may just be a common cold, to just choose one malady.

Mr. HACKBARTH. Now, having said that, I do not think that medical liability, or fear of medical liability, is the only reason that these costs are going up.

Senator HATCH. I do not either.

Mr. HACKBARTH. Of course, one is just new technology. There are more sophisticated pieces of equipment. Much of what is done is truly marvelous.

Senator HATCH. But you have also indicated that utilizing new technologies is there. It is expensive. They have to pay for it, and the way to pay for it is by utilizing it.

Mr. HACKBARTH. Right. And so that leads me to two other factors. One is just the inherent incentives in the fee-for-service system. We now pay physicians more for doing more as opposed to producing good results for patients. That is why we think that Senators Baucus and Grassley have been absolutely right to be in leadership on pay-for-performance as an issue.

The second thing that has not been discussed today that we think is important, is how prices are set for individual physician services. It is an arcane topic, but nevertheless an important one.

We have this elaborate fee schedule that says, this is how much we pay for things relative to one another. We think that there are some significant distortions in that system and, as a result of those distortions, some of these services are far more profitable than others.

Physicians know which ones are more profitable, so their investment is sucked into those services. We think the imaging area is one area in particular where there is some significant mispricing.

Senator HATCH. Mr. Chairman, I would like to hear from each of them if I can. It is that important, I think.

The CHAIRMAN. It is very important. But briefly, please, because there are other Senators who want to inquire.

Senator HATCH. If you could speak briefly, I would like to have each of you take a crack at these.

The CHAIRMAN. We also have another round, too, if you want to wait and address it in the next round.

Senator HATCH. I understand.

The CHAIRMAN. Why don't you go ahead?

Senator HATCH. I think it is important.

Dr. ORSZAG. I will be brief. First, with regard to technology, clearly it is one of the key cost drivers in the health care system. The key question is evaluating where, say, an MRI scan is appropriate and may affect the course of treatment and where it is unnecessary. It is getting at exactly that kind of decision point that will be crucial to containing cost growth without impairing health.

With regard to malpractice expenses, there is a direct effect on the Sustainable Growth Rate formula because that is part of the relative value that plays into covered expenses, but that share is very small in terms of a direct effect. CBO has written, and I will send you the report, more broadly on medical malpractice and its effects on health care costs.

Senator HATCH. I would be glad to have it.

Dr. Wilson, I have given you a home run ball here, and now I expect you to hit it.

Dr. WILSON. Thank you. Thank you, Senator.

The CHAIRMAN. Briefly. Briefly.

Dr. WILSON. Yes. The remarks about the climate of fear that does result in defensive medicine and whatever number, it is in the billions. I would like to demur a little about the incentives.

It is clear now that a CAT scan will increase your accuracy of diagnosing acute appendicitis from 95 to virtually 100 percent. When I order a CAT scan, I do not get paid any more. What I get is a patient who does better. So let me just suggest that what physicians order is not always to their benefit.

When I order an X-ray for a fractured ankle, I am not the one who does that X-ray, nor who benefits from that X-ray. So I am a little concerned about the haste to suggest that physicians order only because of the incentives. They really do order because they think it is in the best interests of the patient.

Senator HATCH. I am not suggesting that.

Dr. WILSON. I understand. Thank you.

Senator HATCH. I am talking about unnecessary medicine.

Dr. WILSON. Right.

Senator HATCH. And malpractice. Could you address that, the influence on malpractice insurance?

Dr. THAMES. I am going to just echo what has been said about the fact that we can over-utilize technology, and somebody is getting paid. The person that reads it, Dr. Wilson is correct, is frequently not the physician who is ordering it.

I do want to say, on the medical malpractice system, Senator, this is another system that is seriously flawed. The person who has a minor injury, but affects the quality of their life for only a few months or so and not permanently, frequently cannot even get their case taken.

On the other hand, it is a lottery system for other people, and the payout is too great. Obviously, the better system would be one which is not a jury system that is a lottery. But it is going to be a long time in this country before we see it.

The CHAIRMAN. Thank you very much. Thank you, Senator.

Senator Smith?

Senator SMITH. Thank you, Mr. Chairman. I want to make note that Chairman Hackbarth is an Oregonian, and I thank him for his service and his presence here today.

I was here when we did the balanced budget agreement as a Congress with President Clinton. Ever since that time, the SGR system and its formula have been roundly criticized in every town hall that I have been in.

As I recall, it is regarded as inequitable and unworkable, since it treats all physicians alike. It does not distinguish between "desirable" and "undesirable" growth in volume, and it fails to reward physicians for better care and better quality, or to take away from those who offer less than that.

Yet, it does strike me that we are at a point where we are putting a Band-Aid, one Congress after the next, on this problem. We have growth in the category of entitlements, and here is obviously Medicare. Then we are looking at a demographic tsunami. It seems to me that this Band-Aid will break just as soon as we apply it.

I wonder if any of you have thought more deeply as to, what is the real answer here? Is it some kind of a basic package that is available? What do we need to do? I doubt we will do it in the 110th Congress, but I suspect in the next decade we will have no other choice. Our history is, we do not make the hard decisions until we have no other option.

Any thoughts on that? Where are we going with health care and what is our solution for the American people and the economic future of our Nation?

Dr. THAMES. Senator, if I could, may I remind you that with AARP, along with the Business Roundtable and the Service Employees' International Union, one of our two major priorities this year is health care reform. That is, to look at providing some basic underlying health care for every citizen in America. It is time for that debate to happen again.

As far as we can, with our allies, we are going to promote that that come up at least by the 2008 elections, that people will try to get a bipartisan group to work on that. We cannot solve this problem intermittently, whether it is for Medicare, when we leave all

the rest of the people uninsured who are not on Medicare, and the children who need services. So, it is time we did that debate.

Senator SMITH. Dr. Wilson?

Dr. WILSON. Yes, Senator. I would like to follow on. Dr. Thames was referring to the Health Coalition for Covering the Uninsured, of which the AMA is a part as well, and has been working with over the past 2 years. I think the bottom line is to say, it is the old case of the balloon: you squeeze it in one place and it balloons in another area.

This is a part of comprehensive reform. As long as we have the 40-plus million of our citizens who are uninsured and, therefore, at increased risk of being ill and dying sooner, who get care in the most expensive ways, people who cannot carry their insurance with them from job to job, with job lock, with the liability issue, the Medicare payment issue, those have to be a part of a comprehensive look at our health care system.

Senator SMITH. Because, in truth, we are spending more on health care with really no better results than any other Nation. Is that not a fact?

Dr. WILSON. We are spending more and not getting as good results as we would hope. I would not want to compare us with the whole world in that regard.

Senator SMITH. Yes. Dr. Orszag?

Dr. ORSZAG. Senator, over the next 40 years, if health care costs continue to exceed economic growth by the same amount as they did over the past 40 years, the Federal share of Medicare and Medicaid alone will be 20 percent of the economy, which is the entire Federal Government today. This is the central problem facing the Federal Government.

CBO is going to be providing more analysis and options to you about what could possibly bend that curve so that you can evaluate possible steps. What I would say is, the opportunity is, there is at least the potential, given the scale of this problem—and it is quite important, given the scale of the problem—to take cost out of the system without harming incentives for innovation or without harming Americans' health. That is the potential that we need to grab.

But obviously the difficulty is exactly how to do it. Earlier we were discussing two sort of intermediate steps that might at least set up the infrastructure that would allow you to start moving in that direction.

Senator SMITH. Chairman Hackbarth, my mailbox gets fuller and fuller with letters from Oregonians who are on Medicare who cannot find a physician. It does seem to me that it is a looming crisis for the government, but it is an immediate crisis for them.

Do you have any thoughts on where we need to go as a country? Because it seems to me if we fix this, patch this one more time, it will just break by the 111th Congress.

Mr. HACKBARTH. I would suggest to you that there are three parts to this. One is, as we have discussed at great length now, we need to, in Medicare, change how we pay for services if we want to get a more efficient system. I bore people with my arcane detail about that, but that is critically important. It is not, by itself, enough.

A second thing that we need to do is look at the long-term financing eligibility and benefit structure of the Medicare program. Those are very, very difficult questions. You know far better than I how difficult they are. They are only going to get more difficult over time.

If people have an opportunity to plan for future retirement and they know Medicare is going to be different than it is today, then they can react and save more and accommodate those differences more easily. If we put this off, put this off, the changes will be more painful than they need to be.

The third item that I would suggest to you is, we need a concerted effort to bring public payors like Medicare together with private payors in important areas so that we are pushing in the same direction. Peter has mentioned one of those: comparative effectiveness.

All payors, public and private, as well as the clinicians, service the patients, and the patients themselves need—deserve—much better information about what works and how alternative treatments compare to one another.

Then payors can begin to use that information to structure benefits, structure payment policies, and the like. It is a public good in the truest sense of the word that requires a public investment in collaboration across the public and private sectors to make it happen.

Senator SMITH. Thank you very much.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. That was very, very informative.

What I would like to do is ask all four of you to just indicate to me which of these would be most efficient and effective in helping us get a handle on the basic question here, the basic question being health care costs, utilization, et cetera.

I am going to list five of these. Tell me which ones you think are most important.

First, just pay for quality. Figure out how we do that better. Two, trying to address, in areas where it occurs, over-utilization by providing some kind of feedback to physicians on their resource use. Third, how to expand comparative effectiveness research. What is the best way to do that? Where? How? Fourth, how do we best encourage primary care and care coordination with the payment system? Also, how do we incentivize the appropriate and greater investment in health information technologies? I am assuming that those are five areas that tend to get at this. I am sure there are others.

I would like, anybody who wants to. We need not go down the line here. Just, why does somebody not just raise his hand if he wants to start talking and just kind of create a little discussion here, get us talking.

Dr. ORSZAG. And we are not allowed to say all five?

Dr. WILSON. Well, thank you, Mr. Chairman. That is exactly what I was going to say. It would be nice if we had the luxury of just one thing on the plate and one magic, silver bullet. We do not. I think all the things you have mentioned are things that need to be worked on, and they need to be worked on at the same time.

The CHAIRMAN. All right. But now, if I might ask, how do we go the next step, though, how to work on it? What suggestions do you have that we start addressing them? I think most people tend to agree, those are some of the major ones we have to work on. I am trying to drive us to the next position, like, what is it we do to advance the ball while we are working on it?

Dr. WILSON. Let me just mention a couple of things. First is to say the medical profession is already working on the issue of quality of care and performance measures. For the last 5 to 6 years, we now have performance measures which represent the best and the state-of-the-art in terms of science. We need to continue to do that.

The second—and actually it is in response a little bit to Senator Stabenow's comment about, why are we not adopting HIT—the question one might ask is, had we solved the SGR problem 5 or 6 years ago and physicians had been able to count on, as business people, an increase in payments which reflected the increased cost of providing care, maybe they could have introduced that earlier than they have now. So I think that the way we pay for what we are doing does have an effect on all these important things as well.

The CHAIRMAN. Who else wants to jump in here?

Mr. HACKBARTH. An item that we have not talked much about is CMS. These are complicated changes to make in the Medicare program.

The CHAIRMAN. Yes, they are.

Mr. HACKBARTH. One of the most important bottlenecks is CMS and its capabilities. There are a lot of good ideas. The problem is translating the good ideas into action and the new payment system.

The CHAIRMAN. Right. That is what I am trying to get at here.

Mr. HACKBARTH. Right. And we have to invest way more money in CMS and that infrastructure. We are trying to run the program on the cheap, and that will not work when you are trying to innovate at the same time.

The CHAIRMAN. And additional CMS resources, you suggest, would be spent how and where?

Mr. HACKBARTH. For things like speeding up the cycle time on demonstrating new ideas. We have some very promising demonstrations under way, but it takes us forever to get them developed and placed, the results examined and translated into policy. That cycle time needs to come way, way down.

Then once we have specific policy proposals, our ability to implement those systems and refine them and maintain them is compromised by an under-investment, not just in staff in CMS, but information systems. We need a 21st-century approach to managing the Medicare program. We are trying to do it on the cheap.

The CHAIRMAN. Yes. All right.

Anyone else? Dr. Thames?

Dr. THAMES. You know, if we look for the quickest bang for the buck and try to lower the cost, out of the things you mentioned to us, I think it would be comparative effectiveness studies, to be completed within a reasonable period of time. We already have some that are there, and to get them to enforce those and pay to see that people use those, and care coordination, particularly for the chronic diseases that take up so much of our budget. If we got a better

handle on those, we could drop the care. Now, I agree that quality, accountability, and others are important.

The CHAIRMAN. Who should do those studies?

Dr. THAMES. Beg your pardon? Who should do those studies?

The CHAIRMAN. The comparative effectiveness studies.

Dr. THAMES. People like the Institute of Medicine. People like MedPAC should be looking at those for us. CMS certainly should be able to give the information to groups. But quality groups. Physician groups are working on those.

The CHAIRMAN. NIH. Is NIH in there? Should NIH be part?

Dr. THAMES. Yes.

The CHAIRMAN. Others? How do we do this?

Dr. THAMES. I do not know who else. I may not have heard you, quite.

The CHAIRMAN. I am just curious. I mentioned NIH.

Dr. THAMES. Oh. NIH. Yes. I am sorry. NIH, certainly. It is one of the premier institutions that does those kind of studies. But, yes. Some of those studies have been done. We need to better use them. Others need to be under way right away.

The CHAIRMAN. Well, I am suggesting we certainly do that with respect to prescription drugs, a comparative analysis of which drugs work and which ones do not, et cetera.

Dr. THAMES. Yes.

The CHAIRMAN. I am sure that could be transferred into a lot of other areas as well.

Dr. THAMES. Absolutely. Like on whether or not coronary artery bypass surgery is better than stents, for instance. Pretty expensive. And which one is really better? So, there are procedures as well as drugs for comparative studies on effectiveness that would greatly affect the costs.

The CHAIRMAN. Right.

Anybody else want to comment on my list of five? Dr. Orszag?

Dr. ORSZAG. I would just say, just on this immediate discussion, that the institutional organization of comparative effectiveness studies is both very important and is sort of not yet advanced enough in the policy debate.

There has been, to my knowledge, one article in *Health Affairs* about different organizational structures for doing this. Policymakers need to think carefully about, should that thing be inside the government, outside the government, quasi-public/private?

The CHAIRMAN. Right.

Dr. ORSZAG. CBO will be presenting options for you.

The CHAIRMAN. Great. I appreciate that very much. My time has expired.

Senator Grassley?

Senator GRASSLEY. Yes. Thank you.

This is a very, very good panel, and very central to things that Senator Baucus and I have been working on for a long period of time, and have still a ways to go, quite obviously.

Dr. Hackbarth, I am going to refer to a chart that is in the AMA testimony. The chart shows payment updates for different providers, so that would be Medicare Advantage, hospitals, nursing homes, and physicians, showing physicians being very low.

But the number shown, 7.1 percent for Medicaid Advantage plans in 2007, is a gross percentage applied to the rates, not to the increase in the actual plan payments.

I think it is important for people to understand the distinction between the 7.1 percent and the increase in actual payments to the plan. So could you briefly explain how you get from the growth rate to the actual plan payments, and tell us the average increase in payments to plans in 2007?

Mr. HACKBARTH. Yes. Senator, I cannot do that off the top of my head, but I would be happy to have the MedPAC staff look at those data and give you a reconciliation and tell you how that process works.

Senator GRASSLEY. All right. Let me ask my staff if we would like to have a staff briefing or have that in writing. Could we put it in writing, please?

Mr. HACKBARTH. Sure.

Senator GRASSLEY. Thank you.

[The information appears in the appendix on p. 61.]

Senator GRASSLEY. Then let us go to Mr. Hackbarth again. You mentioned how various performance management tools could help improve the quality of care. However, lack of information sharing and a low level of investment in information technology is one of the major contributing factors to the high cost of health care.

Health IT still has a long way to go. However, we have some good initial steps in place to measure quality. Would wider options of information technology in health care improve our ability to measure quality?

Mr. HACKBARTH. Yes, unquestionably.

Senator GRASSLEY. All right.

I want to turn to you again on rural health care and associate myself with the remarks of Senator Roberts. But in addition, one of the alternatives applies expenditure targets for physicians' spending to rural areas. As a part of the analysis, you point out that there could be wide payment disparities in neighboring regions.

Today, the physician workforce in Iowa and other rural areas is already disadvantaged by Medicare with lower payments. Will the establishment then of regional updates reshuffle where providers practice and drive them from, or attract them to, rural areas like my State, or I suppose it would apply to Senator Baucus's State as well?

Mr. HACKBARTH. Right. We have not looked specifically at how a regional system would affect particular States like Iowa or Montana, but the concept—and again, roughly half the Commissioners are supportive of expenditure targets.

Among those who support expenditure targets, they believe that a regional target could be used to apply pressure where pressure is most needed, those parts of the country that have dramatically higher Medicare costs per beneficiary, without the quality results to match the expenditure.

In general, I think Montana and Iowa, if I remember the data correctly, tend to be at the low end of the spectrum in terms of cost per beneficiary, and relatively high on the quality measures.

Senator GRASSLEY. Absolutely. Absolutely right.

Mr. HACKBARTH. And so the idea is, let us apply a system that applies pressure not to Montana and Iowa, but to the States with very high expenditures. If we need to get X billion dollars of budget savings, let us not take it out of the low-cost, high-quality States, let us take it out of the high-cost, low-quality States. That is the concept.

Senator GRASSLEY. All right.

In the March, 2000 report of MedPAC, it considered expanding the SGR spending target to include ambulatory care facilities. At the time, MedPAC concluded that an expanded target was unworkable because there was no way to predict and adequately adjust shifts in the site of service with the rigid formulas such as SGR.

The option under path two includes a new system of expenditures that will be applied to all providers. Why does MedPAC's thinking on this now differ from what it concluded in the March, 2000 report?

Mr. HACKBARTH. Yes. The March, 2000 report pre-dates even me, so I cannot speak exactly to that recommendation and the thinking behind it. I can speak to the thinking about having a total cost target as opposed to Part B only.

The reason for doing that is precisely what you are talking about. There is substitution of services. What we want to do is exert pressure on the system without getting in the way of appropriate substitution of services over time as new technology develops, and the like.

If you just cap part of the system the way we do now, you create problems when services move from one location to the other. If you say, what we are concerned about is not just Part B expenditures but total costs, you can have a more fluid system where the dollars go to where they are most efficiently spent.

We would get all providers at the table saying, how can we get the most benefit for our patients within this aggregate dollar expenditure, not just worry about, well, we have to control Part B expenditures. That is not Medicare's problem. It is total costs, not just physician costs.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Dr. Orszag, could you give us an idea as to how we can formulate comparative effectiveness provisions, say as a part of the SGR update, in a way that you can give us a good score? [Laughter.]

The problem we have, clearly—you know better than I—is that we tend to agree that these are good ideas. If we are going to start spending some money on them, you are going to say it is a cost, and it is going to make it much more difficult under this pay-go regime that we have ourselves in right now. So what can we do? How do we write some of these provisions—and there are a lot of ideas here—in a way that they do not cost very much?

Senator GRASSLEY. Can I reinforce what he said from this standpoint? [Laughter.] And it is more generic than the question he asked. But you are new to this job. Of course, you know all about your job, but for a long time I have been saying, you are just like God. Whatever you say. And if you want to know how much you are God, everything you say, if Congress wants to override it, is going to take 60 votes, at least in the Senate. Sixty votes.

So be careful what you say. Do not make our job any harder than you can, because there are 99 Senators, and any one of them can raise a point of order, and then you become more powerful than ever. Now, maybe I should not let you think you are so powerful. [Laughter.] But the fact is, you are.

Dr. ORSZAG. I did not realize I had been elevated to that status. [Laughter.] Let me say two things. One is, I think there are lots of steps, including HIT, including comparative effectiveness, that offer at least the potential—not the guarantee, but the potential—to help bend that curve over the long term, but the cost savings may not show up in the next 10 years. That is just the way it is.

I could advertise that we just put out a budget options volume that has lots and lots of possible offsets for you over the next 10 years, and I understand that things that have up-front costs that, under the pay-go rules, need to be offset and long-term benefits present special challenges. But if that is often the case, making an investment now can pay off long-term, but not immediately.

The CHAIRMAN. Well, why can't we go the other direction? Why can't you tell us some of the things we are doing now—how can I say this? You say that a cost now is a cost now, even though it has future benefits.

But why can't you also—and I am speaking facetiously here, obviously—come up with a proposal or a way to help us say that something, now, is not a benefit? Or if not a benefit, later on it will be. I am not saying it the right way. I am trying to do the reverse of what you are doing on the other side of the ledger.

Dr. ORSZAG. Well, again, the budget scoring rules are what they are, and I guess even God cannot change them. [Laughter.]

The CHAIRMAN. But you are God. [Laughter.] We are asking you to change them. No. I appreciate that. But if you could, in the meantime, give us some guidance as to how we write this stuff in the direction that we all agree we want to go, in a way that does not cost too much, so that we can get there more quickly.

Thank you very much. The hearing is adjourned.

[Whereupon, at 11:58 a.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Statement for Senator Bunning
March 1, 2007
Senate Finance Hearing
Physician Payment

Mr. Chairman, thank you for holding this hearing today.

The physician payment issue is something that Congress has wrestled with for several years, and it is the most important issue that I hear from doctors about every time they visit my office. The doctors in my state are very concerned about how the current physician formula works, and about the amount of payment cuts projected over the next couple of years.

For 2008, the payment cut is projected to be about 10 percent. Over the next eight years, physicians are looking at a 40 percent decrease. This clearly is unsustainable for our doctors and for the Medicare program. Doctors cannot operate their offices and continue seeing Medicare patients with these types of cuts coming in the future.

For several years, Congress has stepped in at the last minute to avert upcoming cuts to physician payments. We did it for 2004, 2005, 2006 and 2007. Now we are looking at what we need to do for 2008.

Ultimately what we need to do is replace the current "Sustainable Growth Rate" formula with something that actually works. The Medicare Payment Advisory Committee is releasing a new report today at this hearing outlining several options, which will hopefully start the dialogue.

Unfortunately, this is an expensive problem to fix and will likely cost billions of dollars. I am very concerned about the rate of spending in the entitlement programs, and whatever we do with Medicare this year we need to keep overall spending in mind.

For example, Medicare spending is projected to total about $391 billion in 2008, but will grow to $503 billion by 2012. At the same time, Medicaid spending will grow from $209 billion to $279 billion.

The President's budget suggested some payment changes to both the Medicare and Medicaid programs, and it is up to this Committee to take a close look at them this year. Whatever we do with the physician payment formula will have to be considered within the larger framework of Medicare reform and overall spending.

I want to thank our witnesses for being here today. This is an important hearing and I am looking forward to hearing from them.

Thank you.

United States Senate
Committee on Finance

Sen. Chuck Grassley · Iowa
Ranking Member

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Opening Statement of Sen. Chuck Grassley
Senate Finance Committee Hearing
"Medicare Payment for Physician Services: Examining New Approaches"
Thursday, March 1, 2007

Medicare physician payment reform is one of the most important issues before Congress. I'm pleased that we have the Chairman of the Medicare Payment Advisory Commission, Glenn Hackbarth, here to testify on the commission's important report on the Sustainable Growth Rate. I am also looking forward to the testimony of our other distinguished witnesses who will give us their views on alternatives to the Sustainable Growth Rate, better known as the SGR.

The SGR attempts to control physician spending and determine the annual physician payment update through spending targets. But the SGR formula is fundamentally flawed and doesn't work the way it was intended.

Without congressional action this year, physicians are now scheduled under the SGR to receive a roughly ten percent payment cut in 2008 and additional 5 percent cuts for at least the next several years. Physician payment rates could decline by a total of 25 percent or more during this period. One of the key questions we need to examine today is how to improve value in Medicare while also controlling spending. We need to move ahead with changes in Medicare designed to reward higher quality and more efficient care.

The current SGR system is not designed to do this. I have two points to make about this. First, Medicare rewards overutilization and inefficiency. It doesn't reward physicians who restrain growth in their services and spend less. And it doesn't deter physicians who prescribe services that aren't necessary. Instead, just the opposite happens. Those who order more tests and visits get paid more by Medicare than those who provide efficient, lower-cost care.

Second, Medicare often rewards poor quality. In other areas of our economy, you get what you pay for. And often the more you spend, the better the quality you get. But Medicare spending has little bearing on quality. Physicians who provide high quality care are not rewarded financially. And those who have to treat their patients for longer periods of time get paid more. Or if there is an avoidable complication you get paid more. Of course, most physicians care deeply about the quality of care they provide to their patients. But the Medicare physician payment system doesn't have the right

incentives that would foster improvements in quality and more efficient care. One good example of this is the fact that Medicare does not provide any financial incentives to invest in information technology. Rewarding higher quality care would do that.

We need to change this equation and identify better ways for Medicare to measure and reward quality. Chairman Baucus and I have been working together to realign incentives in Medicare for some time now. We developed and introduced the Medicare Value Purchasing Act in 2005 which would move the Medicare payment system toward better quality care by gradually extending pay for performance incentives to all providers. I look forward to working with you, Mr. Chairman, to reintroduce that legislation later this year.

The Tax Relief and Health Care Act signed into law in December includes a number of provisions to improve the Medicare program. It takes a critical first step toward improving physicians' quality of care by establishing a voluntary Physician Quality Reporting Program, or PQRI, as it is now known. This program -- the first of its kind for physicians and other eligible professionals -- establishes a 1.5 percent bonus payment for those who report specific, consensus-based, quality measures to the Centers for Medicare and Medicaid Services from July through December of this year.

Today, we begin addressing the challenge of developing a long term solution to the physician payment formula. We must ensure that physicians and other health care providers can afford to practice medicine and deliver health care wherever they are located. We must preserve Medicare beneficiaries' access to physicians. We must provide incentives for more efficient and better quality care. And we must endeavor to reform Medicare payments in a bipartisan manner and fiscally responsible way. We must ensure that physicians do not continue to face the possibility of receiving drastic cuts in their Medicare reimbursement each year, and we must stabilize physician payments in the future. Providing short-term updates for physician payments ultimately just makes the problem worse. I recognize that this is a tall order for us to fill so I'm very pleased that we have these noted experts and stakeholders with us today as we begin to move forward and examine the alternatives in the MedPAC Report.

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Assessing Alternatives to the Sustainable Growth Rate System

March 1, 2007

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Committee on Finance
U.S. Senate

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Chairman Baucus, Ranking Member Grassley, distinguished Committee members, I am Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss alternatives to the sustainable growth rate (SGR) system used in Medicare's physician payment system.

Medicare pays for physician services on a fee-for-service basis using a resource-based relative value scale. Each service is assigned a weight reflecting the resources needed to furnish it. Payment is determined by multiplying a service's weight by a national physician payment rate, called the conversion factor.

Currently, as specified in statute, the annual update to the conversion factor is determined under the SGR, based on an expenditure target that is tied to growth in the gross domestic product (GDP). The SGR is widely considered to be flawed; it neither rewards physicians who restrain volume growth nor punishes those who prescribe unnecessary services. Some critics contend the SGR may actually stimulate volume growth. Other observers believe that, despite its flaws, the SGR has helped curb the increase in Medicare spending for physician services by alerting policymakers that spending is rising more rapidly than anticipated and constraining the ability of policymakers to increase fees.

Slowing the increase in Medicare outlays is important; indeed it is becoming urgent. Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary out-of-pocket costs through higher Part B and supplemental insurance premiums as well as higher copayments.

The Deficit Reduction Act of 2005 (DRA) requires MedPAC to examine alternative mechanisms for establishing expenditure targets. We also considered ways to reconfigure the existing SGR to improve its performance. We have reviewed the pros and cons of the different alternatives and outlined two possible paths for the Congress to follow. Significant disagreement exists within the Commission about the utility of expenditure

targets. Moreover, the complexity of the issues makes it difficult to recommend any option with confidence. Absent careful development and significant investment, the risk that a formulaic expenditure target will fail and have unintended consequences is substantial.

Despite disagreement about expenditure targets, the Commission is united on this: Whether or not the Congress elects to retain some form of expenditure target, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to change the inherent incentives in the fee-for-service system to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, developing incentives to coordinate care, using comparative-effectiveness information, and bundling payments to reduce overutilization.

An expenditure target, however designed, cannot substitute for improvements to Medicare's payment systems; at best, it may be a useful complement. An expenditure target alone will not create the proper incentives for individual physicians or other providers; indeed, there is a risk that—in the absence of other changes—constraint on physician fees will stimulate inappropriate behavior, including the very increases in volume and intensity that the target system purports to control. It is better to think of an expenditure target as a tool for altering the dynamic of the policy process than as a tool for directly improving how providers deliver services. An expenditure target alerts policymakers that spending is rising more rapidly than anticipated and leads to an annual debate over the update to the physician payment rate. That debate may also influence the behavior of providers: To avoid rate decreases, they could be compelled to support payment reforms that they might otherwise find objectionable.

The Congress, then, must decide between two paths. One path would repeal the SGR and not replace it with a new expenditure target. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and

other providers to furnish higher quality care at a lower cost. If it pursues this path, the Congress would need to make explicit decisions about how to update physician payments. Alternatively, the Congress could replace the SGR with a new expenditure target system. A new expenditure target would not reduce the need, however, for a major investment in payment reform. Regardless of the path chosen, Medicare should develop measures of practice styles and report the information to individual physicians. Medicare should also create opportunities for providers to collaborate to deliver high quality care while restraining resource use.

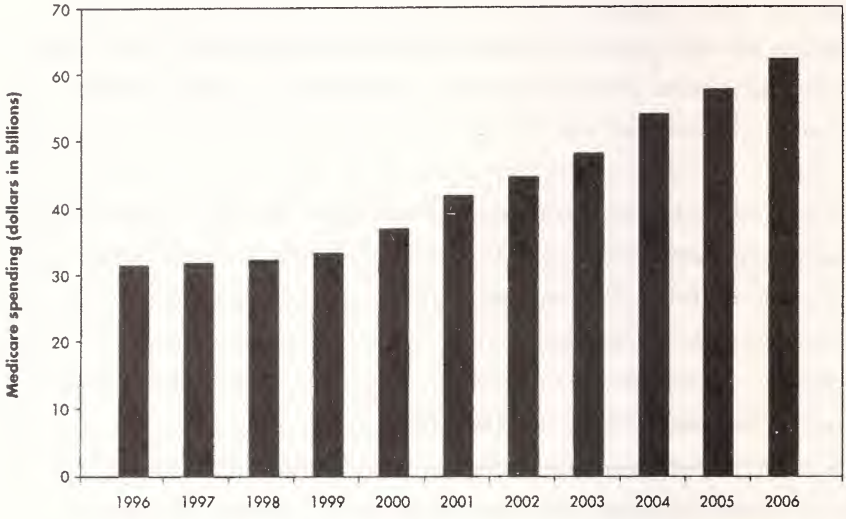
If the Congress chooses to use expenditure targets, the Commission has concluded that such targets should not apply solely to physicians. Rather, they should ultimately apply to all providers. Medicare has a total cost problem, not just a physician cost problem. Moreover, producing the optimal mix of services requires that all types of providers work together, not at cross purposes. For example, physicians and hospitals must collaborate to reduce unnecessary admissions and readmissions. If used, an expenditure target should be designed to encourage all types of providers to work together to keep costs as low as possible while increasing quality. The Congress may also wish to apply targets on a regional basis, since different parts of the country contribute differentially to volume and expenditure growth. Moreover, high-spending areas have not demonstrated higher quality of care.

The sustainable growth rate system

Each year, CMS follows the statutory formula to determine how to update fees for physician services to help align spending with the SGR's expenditure target. The SGR allows growth in spending due to factors that one would expect to affect the volume of physician services: inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to laws and regulations. In addition, the SGR includes an allowance for growth above these factors based on growth in real GDP per capita. Growth in GDP—the measure of goods and services produced in the

United States—is used as a benchmark of how much additional expenditure growth society can afford.

Figure 1. FFS Medicare spending for physician services, 1996–2006



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

The SGR system has been widely criticized. In recent years expenditures for physician services have grown substantially, suggesting that the SGR does not provide a strong check on spending (Figure 1). It does little to counter the inherently inflationary nature of fee-for-service payment. In addition, the SGR is inequitable, treating all providers—regardless of their behavior—and all regions of the country alike.

The SGR also fails to distinguish between desirable increases in volume and those that are not. Some volume growth may be desirable. For example, growth arising from technology or changes in medical protocols that produce meaningful improvements to patients, or growth in services that are currently underutilized, is beneficial. But research

suggests that some portion of volume growth does not advance the health and well-being of beneficiaries. In geographic areas with more providers and more specialists, research has found that beneficiaries receive more services but do not experience better quality of care or better outcomes, nor do they report greater satisfaction with their care.

Table 1. Cumulative actual expenditures for SGR-related services exceeded SGR-allowed expenditures starting in 2002

Year	Cumulative expenditures (in billions)		Difference (in billions)
	Allowed	Actual	
1996	$36.6	$36.6	N/A
1997	86.6	85.9	$0.7
1998	138.7	135.8	2.9
1999	194.1	188.4	5.7
2000	253.4	246.4	7.0
2001	315.4	312.7	2.7
2002	382.5	383.6	-1.1
2003	454.5	461.8	-7.3
2004	531.2	548.9	-17.7
2005	611.3	640.0	-28.7
2006	693.0*	734.9*	-41.9*

Note: SGR (sustainable growth rate), N/A (not applicable). Cumulative allowed and actual expenditures are as of calendar year end. Pursuant to the Balanced Budget Refinement Act of 1999, the SGRs for 2000 and all subsequent years are estimated and then revised twice by CMS, based on later data.
* Estimated.

Source: CMS 2006. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2007. November. http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2007f.pdf.

Medicare spending for physician services has exceeded targeted spending for several years, resulting in the SGR calling for cuts in physician payment rates (Table 1). The Congress has repeatedly prevented these cuts from being implemented without changing the SGR formula or the target. As a result, the cumulative SGR formula calls for larger fee cuts in multiple years. The Medicare trustees project that the SGR will call for annual cuts of about 5 percent well into the next decade. The trustees characterize this projected series of negative updates to physician fees as "unrealistic" because the Congress is unlikely to allow them. But the federal budget's baseline includes the large fee cuts,

making it costly from a budgeting perspective to give zero updates, much less increase fees. If they were implemented, large cumulative cuts would likely compromise access to care. They might also have the unintended consequence of spurring volume growth as physicians attempt to maintain their income.

Using Medicare's physician and other payment systems to improve value

Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers (see text box, p.17). Those policies should reward providers for efficient use of resources and create incentives to increase quality and coordinate care. Policies such as pay for performance that link payment to the quality of care physicians furnish should be implemented. At the same time, Medicare should encourage coordination of care and provision of primary care, allow gainsharing arrangements, bundle and package services where appropriate to reduce overuse, ensure that its prices are accurate, and rethink the program's benefit design and the effects of supplemental coverage. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to physicians. Findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Finally, concerted efforts should be made to identify and prevent misuse, fraud, and abuse by strengthening provider standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

The Congress needs to provide CMS with the necessary time, financial resources, and administrative flexibility to make these improvements. CMS will need to invest in information systems; develop, update, and improve quality and resource use measures; and contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.

DRA-mandated alternatives to the SGR

The DRA requires that we examine the potential for volume controls using five alternative types of sub-national targets—geographic area, type of service, group practice, hospital medical staff, and physician outliers—and consider the feasibility of each. Policymakers should recognize that, by their very nature, these alternatives can only attempt to control total expenditures, not volume. Each alternative has advantages and disadvantages, but without accompanying payment policies that change the inherent incentives of fee-for-service payment, the ability to influence the behavior of individual physicians will be limited.

The Commission has not provided budgetary scores for the alternatives. MedPAC does not produce official scoring estimates. Further, many of the alternatives' administrative implications are unknown. For any of the alternatives, details of the formula—including where the target is set, how to deal with the existing difference between the target and spending, and whether the target is applied only to physician services or is extended more broadly—are the important determinants of projected total spending. Efforts to relax the current SGR (e.g., softening or eliminating the cumulative formula) will be costly under current baseline assumptions. However, the Congress may be able to maintain some expenditure control by retaining the expenditure target in some form.

Geographic area alternative

The geographic area alternative would apply targets to subnational geographic areas. Setting different fee update amounts by region acknowledges that regional practice patterns vary and contribute differentially to overall volume and expenditure growth. Use of different regional updates would improve equity across the country and over time could help reduce geographic variation. However, it is not clear what the optimum geographic unit would be. Choosing the unit involves tradeoffs between physician accountability, year-to-year volatility, and administrative feasibility. Using smaller units, such as hospital referral regions, might increase physician accountability but would also increase year-to-year volatility and be difficult to administer. Large units, such as states or

Part D regions, are more stable and are easier to administer but include too many physicians to encourage accountability.

Using different regional updates would not entirely address the inequities of the current system; for example, a physician who practices conservatively in a high-volume region would still be penalized. Using different regional updates could also create wide disparities in payment rates by area. Beneficiaries crossing the boundaries of geographic areas to seek care also would be an issue that would have to be resolved.

Type-of-service alternative

A type-of-service alternative would set expenditure targets for different types of services, as was done under the volume performance standard (VPS), which preceded the SGR. (Under the VPS, three targets were established—for evaluation and management services, surgical procedures, and all other services.) A type-of-service expenditure target recognizes that expenditure growth differs widely across types of services. Some might prefer this type of target because it would differentiate between services with the greatest growth in volume and expenditures and those with the smallest. This alternative also could be designed to boost payments for primary care services, which some believe are undervalued.

But service-specific targets present a number of difficulties. One problem is that, under such targets, inequities across services and specialties could arise. In addition, setting service-specific targets would implicitly require Medicare to know the optimal mix of services. This would be difficult, since the optimal mix of services will evolve with changes in the population served, patterns of illness, and medical knowledge and technology.

Multispecialty group practice alternative

The Congress asked MedPAC to analyze an alternative to the SGR that might adjust payment based on physicians' participation in group practices, since some studies suggest

that physicians in multispecialty group practices may be more likely to use care management processes and information technology and to have lower overall resource use. But considering the small share of physicians in multispecialty groups (20 percent), and that not all group practices engage in activities that improve quality and manage resource use, payment policies focusing solely on group status may not effectively elicit the desired behavior. Further, using separate targets for group and nongroup physicians could be viewed as inequitable, since efficient physicians in smaller nongroup practices would be ineligible for the payment updates that physicians in multispecialty groups would receive. In addition, rural physicians may have few, if any, opportunities to join group practices. Such small groups of physicians would also increase year-to-year volatility and could be difficult to administer. Establishing payment incentives for performing specific activities associated with better care and lower resource use would likely be more effective than using separate targets based on group practice status.

While the Commission has not recommended a multispecialty group alternative for an expenditure target, such groups may still be an important locus for many of the policy changes that MedPAC believes are important. For example, these groups could serve as accountable care organizations (ACOs), together with independent practice associations (IPAs), hospital medical staffs, and other organized groups of physicians. The Commission's preliminary research has found that beneficiaries who regularly see physicians in multispecialty groups appear to use fewer resources than other beneficiaries. Multispecialty groups may be more likely to incorporate incentives to control resource use and monitor and influence practice styles, which may encourage providers to better coordinate care and ensure that patients are appropriately monitored and receive necessary follow-up care.

Hospital medical staff alternative

A hospital medical staff target system would use Medicare claims to assign physicians and beneficiaries to one type of ACO based on the hospitals they use most. Even if some physicians have little or no direct interaction with a hospital, they can be assigned to the

group based on the hospital most of their patients use. This option creates a virtual physician group using the extended hospital staff as the organizational focal point. Initially, Medicare could collect and distribute information about the practice patterns of different groups. Ultimately, that information could be used to adjust payments for differences in resource use and quality.

Using hospital medical staffs as ACOs could better align incentives to control expenditures. The hospital could provide an organizational locus for physicians in the area to come together to monitor and influence practice styles. Although the size of the groups would vary substantially, each of them would be much smaller than the current national pool. Individual physicians could therefore more readily see a link between their own actions and their group meeting its target. Over time, this alternative is intended to induce physicians and other providers to practice more as a system, optimizing care delivery and reducing overall expenditures.

There are significant barriers to this alternative. Some argue that hospitals and physicians are competitors who will not easily collaborate with one another, making this type of ACO an unlikely vehicle for change. Such small groups of physicians would increase year-to-year volatility and could be difficult to administer. Physicians may resist having Medicare assign them to an entity to which they may feel little or no affinity. Physicians who rarely refer patients for hospital care may be particularly resistant. Finally, there may be additional legislative changes to allow sharing of funds that would be required to implement this alternative.

Outlier alternative

Medicare could identify physicians with very high resource use relative to their peers. CMS could first provide confidential feedback to physicians. Then, once greater experience and confidence in resource-use measurement tools were gained, policymakers could use the results for additional interventions such as public reporting, targeting fraud and abuse, pay for performance, or differential updates based on relative performance.

The major advantage of this alternative is that it would promote individual accountability and would enable physicians to more readily see a link between their actions and their payment. However, a number of technical issues would need to be resolved. Implementation of an outlier system based on episode groupers may prove difficult if physicians cannot be convinced of the validity of episode grouping tools. Physicians will need to be confident that their scores reflect the relative complexity of their patient mix and that they are being compared to an appropriate set of peers. There would likely be considerable controversy around initial physician scores as some physicians realized that their practice patterns were not in line with those of their peers.

Reconfiguring the national target system

We also considered a reconfiguration of the current national target. For example, the current system could be changed to moderate or eliminate the cumulative aspect of the spending targets. Another option is to implement an additional allowance corridor around the allowed spending target line. Both options would relieve some of the budget pressure and result in more favorable updates but also would increase total expenditures and would not change the inflationary incentives inherent in fee-for-service payment.

Other changes could be made to the physician payment system to address services that are growing quickly. Such growth may signal that relative prices for those services do not reflect the time and complexity of furnishing them. In examining such services, the Secretary would need to take into account changes in both the number of physicians furnishing the services to Medicare beneficiaries and the number of hours physicians worked. CMS could use the results from these analyses to flag services for closer examination of their relative work values. Alternatively, the Secretary could automatically correct such mispriced services and the Relative Value Scale Update Committee could then evaluate these changes during its regular five-year review.

Choices for the Congress on expenditure targets

There are two paths the Congress could take. The Commission did not reach a consensus on which path is best. The issues surrounding the use of expenditure targets are complex, the information requirements are many, and the full effects are almost unknowable; in addition, the risk of failure and unintended consequences is high. Nevertheless, some Commissioners believe it is prudent to retain an expenditure target to limit rate increases and to provide leverage with providers to encourage them to embrace reforms they might otherwise oppose. At the same time, other Commissioners fear that undue restraint on rates may impede access to care in the long run. Moreover, across-the board restraint that fails to distinguish between good performers and poor performers may encourage providers to engage in undesirable behavior to maintain their profitability—for example, ordering services of marginal value or seeking to furnish services with payments that are high relative to costs.

Despite disagreement about the utility of expenditure targets, the Commission is united on this key point: Whether or not the Congress elects to retain some form of expenditure target, a major new investment should be made in Medicare's capability to develop, implement, and refine fee-for-service payment systems to reward quality and efficient use of resources while improving payment equity, as discussed below. An expenditure target, however designed, is not a substitute for improving Medicare's payment systems; at best, it may be a useful complement. An expenditure target by itself cannot create the proper incentives for individual physicians or other providers. A target is a tool for improving the dynamics of policymaking, not health care delivery.

Following are two alternative paths for the Congress to consider.

Path 1

The first path would repeal the SGR. No new system of expenditure targets would be implemented. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish lower

cost and higher quality care (see text box, p. 17). Increasing the value of Medicare in this way will require:

- ***Changing the payment incentives.*** Policies must be implemented that link payment to the quality of care physicians and other providers furnish. MedPAC's pay-for-performance recommendations would move toward correcting the problem of lack of incentives for quality care. At the same time, Medicare needs to encourage coordination of care and provision of primary care, ensure that its prices are accurate, allow gainsharing arrangements, and bundle and package services where appropriate to reduce overuse. ACOs like physician groups and other combinations of providers can be encouraged as a means to improve quality and reduce inappropriate use of resources. Medicare should also rethink the program's benefit design and the effects of supplemental coverage.

- ***Collecting and disseminating information.*** Variation in practice patterns may reflect geographic differences in what physicians and other providers believe is appropriate care. To reduce this variation, providers need information about how their practice styles compare with those of their peers. Ultimately, such information could be used to adjust payments to physicians. In addition, findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Both of these are activities in which collaborating with the private sector could lead to wider adoption and greater impact.

- ***Redoubling efforts to identify and prevent misuse, fraud, and abuse.*** This effort includes supporting quality through the use of standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

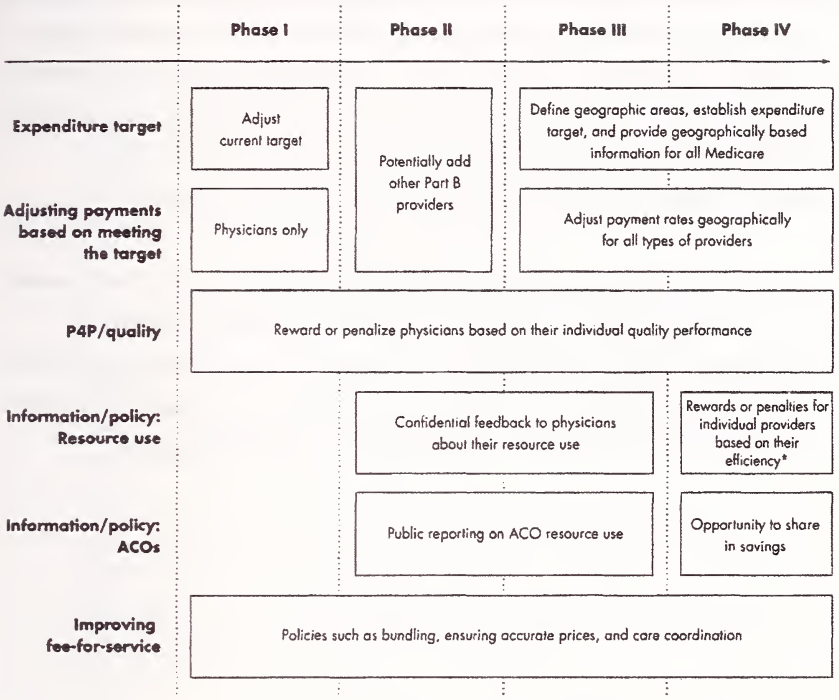
Path 2

The second path would pursue the approaches outlined in path 1 but would also include a new system of expenditure targets (Figure 2). As policymakers grapple with the budgetary consequences of volume and expenditure growth, the presence of an expenditure target may prompt more rapid adoption of the approaches in path 1, since it will put financial pressure on providers to change. If the Congress determines that a target is necessary to ensure restraint on fee increases, the Commission has concluded that such a target should embody the following core principles:

- encompass all of fee-for-service Medicare,
- apply the most pressure in the parts of the country where service use is highest,
- establish opportunities for providers to share savings from improved efficiency,
- reward efficient care in all forms of physician practice organization, and
- provide feedback with the best tools available and in collaboration with private payers.

In keeping with these principles, the expenditure target should not be borne solely by physicians. Rather, it should ultimately be applied to all providers to encourage different providers to work together to keep costs as low as possible while increasing quality. The Congress should also consider applying any expenditure target on a geographic basis, since different parts of the country contribute differentially to volume and expenditure growth. If an expenditure target reflects the limits of what society wants to pay, the greatest pressure should be applied to those areas of the country with the highest per beneficiary costs and the greatest contribution to Medicare expenditure growth.

Figure 2. Timeline for path 2


Phase I
Phase II
Phase III
Phase IV
Expenditure target
Adjust current target
Potentially add other Part B providers
Define geographic areas, establish expenditure target, and provide geographically based information for all Medicare
Adjusting payments based on meeting the target
Physicians only
Adjust payment rates geographically for all types of providers
P4P/quality
Reward or penalize physicians based on their individual quality performance
Information/policy: Resource use
Confidential feedback to physicians about their resource use
Rewards or penalties for individual providers based on their efficiency*
Information/policy: ACOs
Public reporting on ACO resource use
Opportunity to share in savings
Improving fee-for-service
Policies such as bundling, ensuring accurate prices, and care coordination

Note: P4P (pay for performance), ACO (accountable care organization).
* Providers receive rewards or penalties if they are not part of ACOs.

Geographically adjusted targets, even if applied at the level of metropolitan statistical areas, are still too distant from individual providers to create appropriate incentives for efficiency. Creating proper incentives for improved performance—whether for physicians or other providers—will require much more targeted incentives. Rewards and penalties must be based on the performance of provider groupings that are small enough for the providers to be able to work together to improve. Therefore, within each geographic area, measurement of resource use would show how physicians compare with their peers and would reveal outliers. The comparisons could show the resource use of individual

physicians and of groups of physicians belonging to ACOs, such as integrated delivery systems, multispecialty physician groups, and collaborations of hospitals and physicians. ACOs, in turn, would have to meet eligibility criteria but would then be able to share savings with the program if they furnish care more efficiently than the trend in their area. Episode groupers and per capita measures are tools for measuring resource use, and they could become tools that define payment adjustments for physicians who remain committed to solo or small practice outside the confines of larger organizations.

This expenditure target system would address three goals simultaneously. First, it would address geographic disparities in spending and the volume of services. Second, by departing from the existing national SGR and allowing providers to organize into ACOs, it would improve equity and encourage improvements in the organization of care. Third, providers would receive actionable information to change their practice style.

Improving Medicare's value

Medicare should change payment incentives by:

- *Linking payment to quality by basing a portion of provider payment on performance.* The Commission has found that two types of physician measures are ready to be collected: structural measures associated with information technology (such as whether a physician's office tracks patients' follow-up care) and claims-based process measures, which are available for a broad set of conditions. To implement pay-for-performance, CMS must be given the authority to pay providers differentially based on performance. Such a program should be budget neutral, with monies set aside redistributed to providers who performed as required.
- *Encouraging coordination of care and use of care management processes, especially for chronic care patients.* There are a number of care coordination and care management models Medicare could implement. For example, beneficiaries with chronic conditions could volunteer to see a specific physician or care provider for the complex condition that qualifies them to receive care coordination/care management. That physician would serve as a sort of medical home for the patient. Payment for services to coordinate care would be contingent on negotiated levels of performance in cost savings and quality improvements.
- *Ensuring accurate prices by identifying and correcting mispriced services.* CMS should reduce its reliance on physician specialty societies to identify misvalued services so that overvalued services are not overlooked in the process of revising the physician fee schedule's relative weights. CMS should also update the assumptions it uses to estimate the practice expenses associated with physician services. Further, CMS should initiate reviews of services that have experienced substantial changes in volume, length of stay, site of services, practice expense, or other factors that may indicate changes in physician work.
- *Allowing shared accountability arrangements, including gainsharing, between physicians and hospitals.* Such arrangements might increase the willingness of physicians to collaborate with hospitals to lower costs and improve care.
- *Bundling services.* Bundling puts providers at greater financial risk for the services provided and thus gives them an incentive to furnish and order services judiciously. Candidates for bundling include services typically provided during the same episode of care. Bundling the hospital payment and the physician payment for given DRGs could also increase efficiency and improve coordination of care.
- *Promoting primary care, which can lower costs without compromising quality.* Medicare should create better incentives for providers to furnish primary care (e.g., by ensuring accurate prices for primary care services) and for beneficiaries to seek it (e.g., by changing Medicare's cost sharing structure).
- *Rethinking Medicare's cost-sharing structure and its ability to steer beneficiaries to lower cost and more effective treatment options.*

(continued next page)

Improving Medicare's value (continued)

Medicare should collect and disseminate information by:

- *Measuring physicians' resource use over time and sharing results with physicians.* Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than their peers (or what available evidence-based research recommends), and revise their practice styles as appropriate. Once greater confidence with the measurement tool was gained, Medicare could use the results for payments—for example, as a component of a pay-for-performance program that rewards both quality and efficiency. CMS could also use the measurement tool to flag unusual patterns of care that might indicate misuse, fraud, and abuse.
- *Encouraging the development and use of comparative-effectiveness information to help providers and patients determine what constitutes good quality, cost-effective care.* Comparative-effectiveness information could also be used to prioritize pay-for-performance measures, target screening programs, and prioritize disease management initiatives. Given the potential utility of this information to Medicare, and given concerns about the variability in methods and the potential bias of researchers conducting clinical- and cost-effectiveness research, a public-private partnership may be warranted. For example, the federal government could help set priorities for research, while funding could come in part from drug manufacturers, health plans, and pharmacy benefit managers.

Medicare should improve program integrity and provider standards by:

- *Using standards, where appropriate, in physician offices to ensure quality.* MedPAC has recommended that CMS impose quality standards as conditions of payment for imaging services. Other types of services may be candidates for standards as well.
- *Continuing to improve program integrity, capitalizing on the opportunity presented by administrative contractor reform.* Contractor reform may also provide an opportunity for Medicare to enhance its ability to measure performance, improve quality of care, and encourage coordination of care.

Four dimensions of the "SGR problem"

- Encouraging efficiency in the delivery of health care
- Encouraging fiscal discipline in policymaking
- Increasing equity among regions and providers
- Minimizing or offsetting the budget "score"

Increasing value & efficiency in Medicare

- Pricing accuracy
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MEDPAC Medicare Payment Advisory Commission

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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
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March 28, 2007

The Honorable Max Baucus
Chairman, Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Questions for the record from the Finance Committee Hearing "Medicare Payment for Physician Services: Examining New Approaches"

Dear Senator Baucus:

This letter is in response to the questions you sent us on March 9, 2007. Answers to the questions are as follows:

Replies to questions from Senator Baucus

Why does the growth in physician spending vary so dramatically across geographical regions?

The difference in spending is driven largely by utilization differences due to physicians' practice patterns. In particular, John Wennberg, Elliott Fisher, and others have provided compelling evidence that supply-sensitive discretionary services, such as imaging and tests, exhibit wide variation in use geographically with no discernible gains in quality in the high-volume areas. If anything, quality is lower in high-volume areas.

How can Congress justify trying yet again to revise a broken target-based payment formula, and extend it to other Medicare providers, when MedPAC could not make a clear recommendation in this regard?

You are right that the members of the Commission disagree about the utility of expenditure targets broadly. Some believe they are unworkable. Others on the Commission find that expenditure targets may bring some cost consciousness to the policymaking process. All commissioners agreed, however, that if retained, the targets should not just apply to physicians but to all health care providers.

The Commission would not necessarily call for using the same type of reimbursement system for all providers. The existing payment systems could stay intact and then providers' performance (e.g. volume growth) as compared to the target could be one

factor in setting the update for providers in different parts of the country. As we have said earlier, the benefit to an expenditure target is to create a greater sense of fiscal pressure among policymakers when they are contemplating what Medicare spending should be each year. Of course expenditure targets alone will not do the job of changing the payment systems toward value.

Wouldn't it be best to implement reforms from "the ground up" to change the incentives of the payment system, rather than impose a "top down" target on spending?

The Commission agrees that it is important to implement reforms to change the incentives of the payment system. As I replied above, whether or not the Congress elects to retain some form of expenditure target, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to change the inherent incentives in the fee-for-service system to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, developing incentives to coordinate care, using comparative-effectiveness information, and bundling payments to reduce overutilization.

Which of the "value-improving" options presented by MedPAC are ready to be implemented this year? Which will be most effective in incentivizing more efficient, higher quality care?

The policy changes that MedPAC has already recommended – which include pay for performance, measuring resource use, improving the accuracy of pricing, and using standards for imaging providers – could be implemented (or at least started to be phased in) in the next two or three years. Other ideas, like those around care coordination, are already being tested by the program.

Did your findings regarding beneficiary access to physician services distinguish between rural areas and urban ones? If so, could you please elaborate on those findings and comment on how this bodes for the long-term ability of Medicare beneficiaries in rural areas to have sufficient access to care.

Although physicians are located disproportionately in urban areas relative to the U.S. population, rural beneficiaries report similar ease of obtaining physician care as their urban counterparts (in large national surveys). Also, MedPAC surveyed physicians during this past summer (2006) and found that 93% of rural physicians accept at least some new Medicare patients. This share is not statistically different from urban physicians.

Replies to questions from Senator Grassley

Mr. Hackbarth, the AMA has a chart showing payment updates for different providers, including Medicare Advantage plans. But the number shown – 7.1 percent for M-A plans in 2007 – is the growth percentage applied to the rates, not the increase in actual plan payments. I think it's important for people to understand the distinction between that 7.1 percent and the increase in actual payments to plans. Dr. Hackbarth, could you briefly explain how you get from the growth rate to actual plan payments and tell us what the average increase in payments to plans for 2007 was?

The 2007 rates were calculated based on a 7.1 percent increase in national per capita spending growth, an additional 0.7 percent increase from county minimum updates (due to county-level FFS levels), and a reduction of 3.9 percent in the "hold-harmless" adjustment from 2006. These factors yield an overall average increase in the payment rates of approximately 4 percent for 2007 (CMS fact sheet, April 3, 2006).

So we start with a national growth rate of 7.1 percent, but we need to adjust for secular trends in the complexity of coding and for risk differences between the beneficiaries in FFS and plans. As a result of those adjustments, there is a rate increase of 4 percent, for 2007. However, payments could increase by more than 4 percent if plan enroll beneficiaries with higher risk scores or beneficiaries from higher-payment areas

Mr. Hackbarth, the MedPAC report found that structural measures associated with health information technology (IT) are ready to be collected by physicians in a Medicare system where incentives are realigned to link physician payment to quality performance, such as a physician's office using health IT to monitor a patient's follow-up care. In the Tax Relief and Health Care Act of 2006, Congress charged the Department of Health and Human Services with the responsibility for identifying the measures to be used for physicians reporting on quality measures in 2008 and directed HHS to include structural measures, such as the use of electronic health records and electronic prescribing technology, in those quality measures. Nevertheless, many physicians who serve a large number of Medicare patients in rural and medically underserved areas are not yet using health IT systems, in large part because of the cost of adopting information technology. There is also a growing scarcity of physicians in many rural areas which is expected to increase in the foreseeable future. How could a pay for performance system provide incentives for physicians to adopt electronic health records, e-prescribing, and other health information technology? Are there particular incentives that should be considered for physicians in rural areas, and those serving a large percentage of Medicare patients? Could additional reimbursement for expanded use of telemedicine play a role?

When MedPAC studied the issue of health IT, it concluded that the primary federal government role should be to become a more responsible and prudent purchaser. Including IT in a pay-for-performance program can shift the physician's return on investment in information technology. By including measures of IT functionality in the payment distributed in a pay-for-performance program, Medicare is sending a strong signal that using IT to improve the quality of beneficiary care will be rewarded. In addition to improving the return on investment for IT, focusing on the objective—better quality—provides guidance to physicians and vendors about how the IT systems should be designed and used. Rewarding IT functionality is also an incentive to build the capacity for physician offices to be able to measure, report on, and improve care on other measures over time. By contrast, just giving money to providers to purchase IT doesn't create a strong enough incentive to use it in everyday practice.

The Federal government should also be involved in important activities to standardize products and the language used in IT to enhance interoperability. These activities address other barriers to adoption and are an important complement to providing financial incentives through pay for performance.

The Commission did not specifically comment on whether physicians in rural areas merited special treatment with respect to pay for performance and incentives to adopt IT, although certainly we heard of examples of IT diffusion in rural areas. Examples are the Geisinger System in Pennsylvania and a panelist from rural Colorado who presented on his practice's investment in electronic health records. For physicians serving a large percentage of Medicare patients, a pay-for-performance program would have the greatest potential to improve the quality of care for Medicare beneficiaries.

MedPAC has not taken up the question of expanded use of telemedicine in its discussions.

Replies to questions from Senator Bunning

> **The second pathway suggested by MedPAC would replace the current physician formula with a new formula of expenditure targets and expand it to all providers under fee for service, among other things. The current physician formula hasn't worked well. What are the risks -- or benefits -- in using the same type of reimbursement system for all providers?**

The Commission would not necessarily call for using the same type of reimbursement system for all providers. The existing payment systems could stay intact and then providers' performance (e.g. volume growth) as compared to the target could be one factor in setting the update for providers in different parts of the country. As we have said earlier, the benefit to an expenditure target is to create a greater sense of fiscal pressure among policymakers when they are contemplating what Medicare spending should be each year; the targets could also put physician organizations under pressure to

participate in activities they might otherwise resist. Of course expenditure targets alone will not do the job of changing the payment systems toward value.

Replies to questions from Senator Stabenow

Does MedPAC believe that the physician community has been appropriately involved and adequately represented in the analysis of the current payment system and development of proposals for fixing the system?

Yes. MedPAC staff met representatives of many different specialty societies, as well as the American Medical Association, in completing its work. Those groups have provided MedPAC with position papers and more informal views about the current payment system and the problems they see with it. In addition, MedPAC Commissioners include five physicians and two nurses, who have helped shaped the ideas expressed in the report.

MedPAC's Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System (March 1, 2007) does not make specific recommendations. Does Congress have the information we need to move forward with establishing a new payment system at this point? If not, what other information do we need?

It is not clear that additional information is what is needed here. What the Congress needs to decide is whether to retain or drop the expenditure target. This decision rests in part on the Congress's own views of the value of these targets in influencing policy, particularly in light of long-run program sustainability, and the realities of the budget process. The members of the Commission disagree about the utility of expenditure targets. Some believe they are unworkable. Others on the Commission find they may bring some cost consciousness to the policymaking process.

Despite disagreement about expenditure targets, the Commission is united on this: Whether or not the Congress elects to retain some form of expenditure target, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to change the inherent incentives in the fee-for-service system to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, developing incentives to coordinate care, using comparative-effectiveness information, and bundling payments to reduce overutilization.

How can we determine whether the volume of physician services currently being provided, and projected under different payment systems, is appropriate or inappropriate?

This is a complicated problem. Some volume growth may be desirable, such as that arising from technology or changes in medical protocols that produce meaningful gains to patients. Growth in provision of services that have been underused is also beneficial. But provision of unnecessary services may expose some beneficiaries to needless risks. The problem is that not all volume represents necessary services. John Wennberg, Elliott Fisher, and others have provided compelling evidence that supply-sensitive discretionary services, such as imaging and tests, exhibit wide variation in use geographically with no discernible gains in quality in the high-volume areas. If anything, quality is lower in high-volume areas.

The Commission has been exploring the idea of developing comparative effectiveness information to inform providers, patients, and policymakers about the value of services, drugs, and technology. This sort of analysis has the potential to identify which services have the greatest payoff in terms of effectiveness of treatment, and which are only marginally beneficial.

> **Previous MedPAC reports have indicated a concern that consecutive cuts to physician payments could threaten access to care, particularly access to primary care services, over time. The concern has also been raised that current payment policies could discourage medical students and residents from becoming primary care physicians. Does MedPAC continue to believe that the cuts that would result from the SGR could result in access problems, and fewer primary care physicians?**

Although the current picture of access to physician services is good, we continue to believe that cuts over multiple years could result in access problems broadly. We also continue to be concerned that the current payment and delivery system is discouraging physicians from pursuing careers in primary care. Some of our policy ideas – improving accuracy of pricing, encouraging care coordination, measuring resource use, pay-for-performance programs – could improve the environment for primary care physicians.

> **Previous MedPAC reports have indicated that the SGR system should be repealed. Does MedPAC still believe that the SGR system should be repealed?**

All the Commissioners agreed that an expenditure target system that applies only to physicians should not continue. However, as we took up discussion of the sustainable growth rate in response to the Congress's mandate, we found that the members of the Commission disagree about the utility of broader expenditure targets. While some believe they are unworkable, reflecting our earlier position, others on the Commission find they have the value of bringing some cost consciousness to the policymaking process.

Previous MedPAC reports have included recommendations for physician payment updates based on MEI, and MedPAC again recommends a 1.7% update for 2008 in the March 2007 Report to the Congress: Medicare Payment Policy. Does MedPAC recommend that any physician payment system adopted provide an annual payment update of at least MEI?

You are correct that our most recent recommendation for the update for physician payments calls for a 1.7 percent update for 2008, which represents the most recent forecast of the increase in physicians' input costs less an expectation for productivity improvement. For succeeding years, the update should be arrived at based on an assessment of payment adequacy that would take into account a range of factors, including beneficiaries' access to care and the costs associated with the efficient provision of services.

Has MedPAC examined the impact rising Part B premium increases would have on beneficiaries?

Yes. In our March 2007 report we state the following: the amount beneficiaries pay (primarily for Part B and Part D) is projected to make up a steady 12 percent to 13 percent of total program revenue. The dollar amounts of those premiums will require growing shares of beneficiaries' incomes. Part B premiums for 2007 are $93.50 per month (or $1,122 for the year), a $5 per month increase (5.6 percent) over the 2006 amount. CMS estimates that about 4 percent of Part B enrollees will pay higher premiums based on income. Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 11 percent—as high as 17 percent in 2005. Meanwhile, monthly Social Security benefits, which averaged around $900 per month in 2005, grew by about 3 percent annually over the same period. Under current hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in a beneficiary's Social Security benefit. The dollar amount of recent increases in Part B premiums has absorbed 30 percent to 40 percent of the dollar increase in the average Social Security benefit.

The returns of health IT accrue to payers and patients, but providers must pay for the acquisition and implementation of these systems – which can be very expensive. How can the federal government encourage adoption of health information technology among Medicare providers?

MedPAC recommended that the primary federal government role should be to become a more responsible and prudent purchaser. Including IT in a pay for performance program can shift the physician's return on investment in information technology. By including measures of IT functionality in the payment distributed in a pay for performance program, Medicare is sending a strong signal that using IT to improve the quality of beneficiary care will be rewarded. In addition to improving the return on investment for

IT, focusing on the objective—better quality—provides guidance to physicians and vendors about how the IT systems should be designed and used. Rewarding IT functionality is also an incentive to build the capacity for physician offices to be able to measure, report on, and improve care on other measures over time.

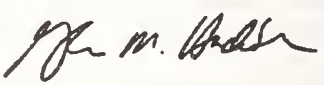
The Federal government should also be involved in important activities to standardize products and the language used in IT to enhance interoperability. These activities address other barriers to adoption and are an important complement to providing financial incentives through pay for performance.

> **In 2005, seventeen years after Congress established a Medicare screening benefit for mammography, the utilization rate for that benefit stood at only 33%. Similarly, in 2005, seven years after Congress mandated coverage of bone mass measurement, only about 15% of Medicare-eligible women utilized that benefit. CMS has indicated its intent to move Medicare toward a prevention model. Has MedPAC given any thought to what CMS might do to make it more likely that beneficiaries would utilize these critical services?**

The Commission has not looked at these particular preventive services. However, the Commission has been looking at a couple of ideas that could be useful in this area. One idea is developing comparative effectiveness information to inform providers, patients, and policymakers about the value of services, drugs, and technology. This sort of analysis has the potential to identify which services have the greatest payoff in terms of effectiveness of treatment, and which are only marginally beneficial. Another, related, idea is structuring Medicare cost sharing to encourage use of services with the greatest benefit and discourage services with less value.

Again, we appreciate the opportunity to testify on this topic and commend the Committee's leadership in this area. If you have any questions regarding this correspondence, please do not hesitate to contact Dr. Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

CBO TESTIMONY

Statement of
Peter R. Orszag
Director

Medicare's Payments to Physicians: Options for Changing the Sustainable Growth Rate

before the
Committee on Finance
United States Senate

March 1, 2007

This document is embargoed until it is delivered at 10:00 a.m. (EST) on Thursday, March 1, 2007. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, Senator Grassley, and Members of the Committee, I am pleased to appear before you today to discuss Medicare's payments to physicians.

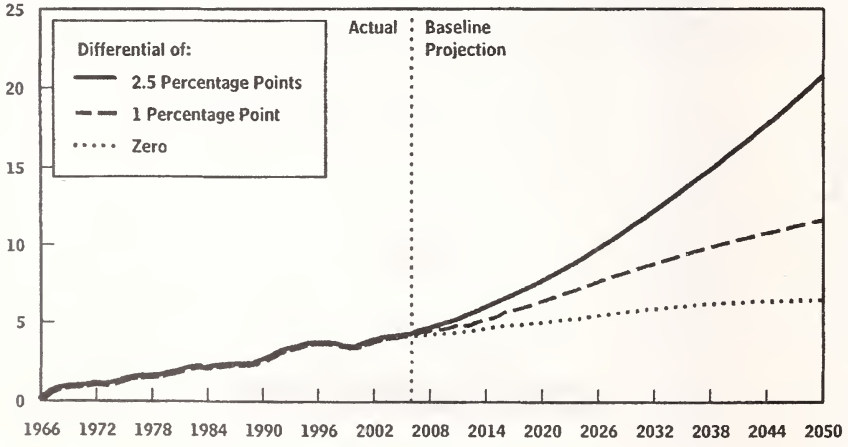
Since this is my first appearance before this Committee as Director of the Congressional Budget Office (CBO), I would also like to take the opportunity to underscore that the key long-term fiscal problem facing the nation involves projected health care costs (see Figure 1).

Policymakers face both challenges and opportunities in addressing projected growth in health care costs. Over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private-sector health markets. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing cost growth in the health sector as a whole. A variety of evidence suggests opportunities to constrain health care costs without adverse consequences. So a central challenge will be to restrain cost growth without harming incentives for innovation or Americans' health (and perhaps even improving it). Moving the nation toward that possibility—which will inevitably be an iterative process in which policy steps are tried, evaluated and perhaps reconsidered—is essential to putting the country on a sounder long-term fiscal path.

Figure 1.

Total Federal Spending for Medicare and Medicaid Under Different Assumptions About the Health Cost Growth Differential

(Percentage of gross domestic product)



Sources: Congressional Budget Office; Office of Management and Budget.

Note. The health cost growth differential refers to the number of percentage points by which the growth of annual health care spending per beneficiary is assumed to exceed the growth of nominal gross domestic product per capita.

With that broader point in mind, let me turn to the immediate topic of this hearing. The Supplementary Medical Insurance program (Part B of Medicare) uses a fee schedule to pay for covered medical services provided by physicians. According to CBO's projections, payments to physicians under the fee schedule will amount to $60 billion in fiscal year 2007, or 14 percent of Medicare's total spending for benefits ($425 billion) this year. Physicians' decisions, though, influence a much larger share of Medicare resources than suggested by that comparison.

The focus of my testimony is how physician fees are updated each year and potential options for changing that system. My testimony makes four main points:

- The current mechanism for updating payment rates for physicians' services—the Sustainable Growth Rate (SGR) method—entails a target level of expenditures (measured on both an annual and a cumulative basis) and a method for adjusting payment rates in an attempt to bring expenditures in line with the targets over time. If the SGR method operates as currently specified, CBO estimates that fees for physicians' services will be reduced by about 10 percent in 2008 and around 5 percent annually for at least several years after that.

- Legislation has prevented the reductions called for by the SGR mechanism from taking effect in recent years, and the Congress may choose to override the SGR mechanism again or may choose to change or replace it in the future. CBO's budget baseline assumes that the SGR mechanism will be implemented as currently specified, and replacing projected reductions in payment rates with annual increases would be costly. For example, repealing the SGR mechanism and allowing physician fees to rise in line with the Medicare economic index (MEI) would increase expenditures by an estimated $262 billion over the next 10 years.[1]

- The SGR issue provides one illustration of the powerful role played by incentives in the health sector: Changes in fees will affect the behavior of physicians. For example, evidence suggests that fee reductions such as those implied by the SGR mechanism would result in a partially offsetting increase in the volume and intensity of services provided by physicians.[2] In addition, the future fee

1. The Medicare economic index measures changes in the cost of physicians' time and expenses; it is a weighted sum of the prices of inputs in those two categories. Most of the components of the index come from the Bureau of Labor Statistics. Changes in the cost of physicians' time are measured using changes in nonfarm labor costs. Changes in "all-factor" productivity are also incorporated into the index as a way of accounting for improvements in physicians' productivity. As a result of the adjustment for productivity, the MEI is lower than the increases in input prices.

2. "Intensity" refers to the complexity of services utilized in caring for patients. For example, use of a computerized axial tomography (CAT) scan rather than an x-ray represents an increase in intensity.

schedule implied by the SGR mechanism could impair Medicare Part B beneficiaries' access to physicians.

- Finally, and perhaps most fundamentally, the task of setting payment rates for Medicare services must be addressed in the context of challenging long-run budgetary trends. In that context, it seems particularly useful to examine options for using the payment system to encourage the health system to deliver high-value and cost-effective care. Restructuring the SGR mechanism could offer an opportunity to provide stronger incentives toward this objective. Former administrator of the Centers for Medicare and Medicaid Services (CMS) Mark McClellan has described that objective as moving the fee-for-service system toward a "fee-for-value" one.

Historical Background

Since the Medicare program was created in 1965, several ways of determining how much it pays physicians for each covered service have been used. Initially, the program compensated physicians on the basis of their charges and allowed them to bill beneficiaries for the full amount above what Medicare paid for each service. In 1975, Medicare payments were still linked to what physicians charged, but the annual increase in fees was limited by the Medicare economic index. Because those changes were not enough to prevent total payments from rising more than policymakers desired, from 1984 though 1991 the annual change in fees was determined by legislation.

Starting in 1992, the charged-based payment system was replaced by the physician fee schedule. The fee schedule bases payment for individual services on the estimated relative resources used to provide them. The schedule itself was not intended to control spending—it was designed to redistribute spending among various physicians' specialties. It was updated using a combination of the MEI and an adjustment factor designed to counteract changes in the volume of services being delivered per beneficiary. That adjustment factor, known as the volume performance standard (VPS), was based on the historical trend in volume. However, the VPS mechanism led to highly variable changes in payment rates, and the Congress replaced it with the current Sustainable Growth Rate method starting in 1998.[3]

How the SGR Mechanism Works

The SGR mechanism aims to control spending on physicians' services provided under Part B of Medicare. It does so by setting an overall target amount of spend-

3. For a more detailed discussion of the history of payment rates, see the statement of Douglas Holtz-Eakin, Director, Congressional Budget Office, *Medicare's Physician Fee Schedule*, before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

ing (measured on both an annual and a cumulative basis) on certain types of goods and services provided under Part B: payments for physicians' services as well as payments that Medicare makes for items—such as laboratory tests, imaging services, and physician-administered drugs—that are furnished in connection with physicians' services. Payment rates are adjusted annually to reflect differences between actual spending and the spending target—upward if spending is below the target, downward if spending is above the target.

The SGR mechanism consists of three components, all based on statutory formulas:

- Expenditure targets, which are established by applying a growth rate to spending during a base period;
- The growth rate; and
- Annual adjustments to payment rates for physicians' services, which are designed to bring spending in line with the expenditure targets over time.

The Expenditure Targets

The SGR mechanism establishes both year-by-year and cumulative spending targets. Included in the targets is Medicare's spending on services covered by the physician fee schedule and services provided "incident to" a visit to a physician. The fee schedule determines how much physicians get paid for each of the services they provide. The "incident-to" goods and services include laboratory tests and physician-administered drugs, such as chemotherapeutic ones; payment rates for those services are not determined by the physician fee schedule.[4] Services on that fee schedule accounted for more than 80 percent of all spending counted toward the SGR target in 2006.

The SGR method uses spending that occurred between April 1, 1996, and March 31, 1997, as the base for all future spending counted toward the targets. During that base period, the amount of spending counted under the method totaled $48.9 billion. Each year, the spending target is updated from the base level to reflect the growth rate determined by the SGR formula. That formula produced a sustainable growth rate of 3.2 percent for 1998. Consequently, the expenditure target that year was $50.5 billion ($48.9 multiplied by 1.032).

The annual targets are added together (along with the original base amount) to produce a cumulative target. The cumulative target in 1998 was $99.4 billion ($48.9 billion plus $50.5 billion); according to CMS, the cumulative target in 2006 had reached $693.3 billion.

4. Payments for some services, such as laboratory tests, are based on their own fee schedules, which are usually updated annually for inflation. Payments for physician-administered drugs are based on market prices.

The Growth Rate

The expenditure targets are updated each year by applying a growth rate (the SGR) designed to account for various factors that contribute to changes in Part B spending. That growth rate incorporates the following factors:

- First, it includes an adjustment for inflation that takes into account changes in the prices of goods and services used by physicians' practices and in the prices that Medicare pays for "incident-to" services. The change in prices of goods and services used by physicians' practices is measured by the Medicare economic index. CMS has determined that the aggregate of those factors will be 2.2 percent for 2007.[5]

- Second, the rate incorporates changes in enrollment in Medicare's fee-for-service sector, which CMS estimates will be a decline of 0.9 percent for 2007.

- Third, the SGR incorporates the estimated 10-year average annual growth rate in real (inflation-adjusted) gross domestic product (GDP) per capita, which CMS estimates at 2.0 percent.

- Fourth, the growth rate takes into account the effect of changes in law or regulation that would affect spending for services subject to the SGR mechanism—such as adding coverage of new benefits—which CMS has estimated at -1.5 percent for 2007. That figure will change, however, because recent legislation—the Tax Relief and Health Care Act (Public Law 109-432)—includes provisions that will cause changes in the SGR.[6]

Those four factors are multiplied to yield an overall growth rate of 1.8 percent in 2007:

> Change in physicians' prices (1.022) x change in enrollment (0.991) x change in real GDP per capita (1.020) x changes in law or regulation (0.985) = 1.018

The expenditure target for services covered by the physician fee schedule in 2006 was $81.7 billion. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries.) Increasing the 2006 target by 1.8 percent results in an expenditure target of $83.2 billion for 2007.

In essence, the SGR method allows spending per beneficiary to grow with inflation, with these additional adjustments:

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5. CMS usually sets the payment rates for each year in November of the preceding year.

6. To date, CMS has not publicly announced what the new growth rate for 2007 will be. Before enactment of the Tax Relief and Health Care Act, the Deficit Reduction Act (P.L. 109-362) reduced payment rates for imaging services and made other changes affecting the SGR, contributing to the -1.5 percent change. CMS plans to release a revised estimate of the growth rate for 2007 later this month.

- A reduction that assigns the benefits of productivity improvements to the Medicare program (the MEI includes a productivity adjustment, which is the mechanism for assigning productivity gains to Medicare);

- An increase—which could be considered an allowance for growth in the volume and intensity of services—equal to the real change in GDP per capita; and

- An increase or decrease to reflect any changes in the coverage offered by the program.

Once a determination of the SGR has been made for a given calendar year, it is not necessarily fixed. If actual experience for one or more of the four growth factors differs from the estimates in the original calculation, the SGR for that year can be changed. In other words, if the SGR for 2007 is set assuming that fee-for-service enrollment will decrease by 0.9 percent and in actuality it changes by a different amount, the SGR for that year will subsequently be adjusted. In that case, the rates paid in 2007 would not change, but the cumulative target for subsequent years would be adjusted. The SGR—and therefore the expenditure targets—for a particular year can be retroactively adjusted for up to two years.

Annual Adjustments to Payment Rates

The annual update to payment rates under the physician fee schedule involves two components: an inflation adjustment according to the MEI and an "update adjustment factor." The adjustment factor is based on the relationship between actual spending for services subject to the SGR and the formula's expenditure targets. If actual spending under the SGR does not deviate from the expenditure targets, payment rates under the physician fee schedule are simply increased by the MEI.

If actual spending deviates from the expenditure targets, annual updates to payment rates for physicians' services are adjusted. Those adjustments are designed so that, over a period of several years, cumulative spending will be brought back into line with the cumulative expenditure target. The update adjustment formula takes into account both the relationship between spending in a given year and that year's expenditure target and the relationship between cumulative spending and the cumulative expenditure target.

If actual spending is more than the targets, the update adjustment factor will be negative (that is, it will reduce the amount of the increase that would otherwise occur to reflect inflation); if actual spending is less than the targets, the update adjustment factor will be positive. The law sets upper and lower limits on the update adjustment factor—it cannot exceed an increase of 3 percent or a reduction of 7 percent. CMS determined that at the end of 2006, cumulative spending was about $43 billion above the expenditure targets and that the update adjustment factor determined by the formula for 2007 would have been -25 percent; therefore, the statutory limit of -7 percent was used. Consequently, in 2007, payment rates for physi-

cians were scheduled to decrease by 5.0 percent: a 2.1 percent inflation adjustment was more than offset by an update adjustment factor of -7 percent.[7] However, the Tax Relief and Health Care Act overrode the formula for 2007 and held payment rates constant at their 2006 level.

It is important to note that under the SGR mechanism, the adjustment factor applies only to the physician fee schedule and not to payment rates for "incident-to" services, which last year accounted for about 18 percent of the spending counted toward the SGR targets. Consequently, the SGR mechanism will adjust payment rates for physicians' services in future years to offset any difference between the rate of growth of spending for "incident-to" services and the growth rate of the SGR expenditure targets. If spending for the "incident-to" services grows faster than the SGR targets, payment rates for physicians' services will be reduced to compensate for that increase. Prior to changes in the way physician-administered drugs were paid for in 2004, such "incident-to" spending experienced several years of double-digit growth. The share of SGR-related spending accounted for by physician-administered drugs increased from about 7 percent in 2001 to nearly 10 percent in 2006.

Experience Under the SGR Mechanism

From 1997 (which is the starting point for measuring expenditures under the SGR method) through 2006, per-beneficiary spending on services paid for under the physician fee schedule grew by 75 percent, or 6.3 percent per year. In contrast, per-beneficiary spending on services paid for by Medicare on a fee-for-service basis grew by 40 percent, or 4 percent per year, over that same time period.

Increases in spending subject to the fee schedule can be attributed to increases in Part B enrollment, in the fees themselves, and in the volume and intensity of services being provided by physicians and to the addition of covered services. Since 1997, enrollment growth in Part B has averaged about 1 percent annually, and the fees that Medicare pays for each service have increased annually by an average of about 2 percent. Although some of the remaining increase has resulted from the addition of covered services, most of the rest is attributable to growth in the volume and intensity of services.

Because of that relatively rapid growth, spending measured by the SGR method has, since 2002, consistently been above the targets established by the formula. In 2006, expenditures counted under the SGR method totaled $94.9 billion, $13 billion more than the $81.7 billion expenditure target for that year. Total spending since the SGR method was put into place in 1997 now stands at about $43 billion

7. $(1 + 0.021) \times (1 - 0.07) = 0.94953$.

above the system's cumulative target.[8] As a result, the SGR mechanism, under current law, will substantially reduce payment rates for physicians' services over the next several years. Payment rates could decline by nearly 40 percent by 2015 if physicians continue to provide services at the current rate.

Recent Legislation Affecting the SGR

Since 2002, the SGR method has called for reductions in physician payment rates. In 2002, payment rates were cut by 4.8 percent, and CMS determined that rates would be further reduced by 4.4 percent in 2003. In the Consolidated Appropriation Resolution of 2003 (P.L. 108-7), the Congress responded to that imminent reduction by allowing the Administration to boost the cumulative SGR expenditure target, thereby producing a 1.6 percent increase in payment rates for physicians' services in 2003.

Spending continued to exceed the target and—if it had been allowed to operate—the SGR mechanism would have reduced payment rates in 2004. The Congress and the President acted to prevent such a reduction. As part of the Medicare Modernization Act (P.L. 108-173), they replaced the scheduled rate reduction with increases of 1.5 percent in both 2004 and 2005. The Deficit Reduction Act held 2006 payment rates at their 2005 level, overriding an impending reduction of 4.4 percent. The Tax Relief and Health Care Act again held overall payment rates constant for 2007.

The budgetary effect of legislative actions to override cuts in 2004, 2005, and 2006 was twofold. Federal spending on Medicare Part B benefits grew more than it would have otherwise. In addition, because of the specification that increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. Under the current SGR rules, growth in spending occurring as a result of those rate increases will eventually be recouped by future adjustments to payment rates. Consequently, the budgetary cost of any future legislative increases in payment rates was increased.

The budgetary effect of the legislation that overrode the cut scheduled for 2007 is different from that of previous legislative actions. The Tax Relief and Health Care Act specifies that holding the rates constant for 2007 should not affect payment rates in any year thereafter. That provision has the effect of allowing a rate reduction that is larger than what the SGR formula would normally allow. In order for 2008 payment rates to be unaffected by the 2007 change, they will have to decline by 10 percent from the 2007 levels. (From that point on, rates will decrease by

8. Those figures include both spending by the Medicare program and beneficiaries' cost-sharing obligations for services. Cost sharing amounts to roughly 20 percent of the total spending counted under the targets.

about 5 percent annually for several more years.) In addition, the law specifies that increases in spending as a result of the rate change in 2007 should be considered the result of a change in law and regulation when determining the SGR expenditure target. Consequently, the increase in spending will not be recouped by future adjustments to payment rates.

The Tax Relief and Health Care Act contains two other provisions that could have an impact on payment rates for physicians' services. One is a voluntary program that will pay providers who comply with certain reporting requirements during part of 2007 a bonus of 1.5 percent of the payments they receive during that period. The law also appropriates $1.35 billion to establish the Physician Assistance and Quality Improvement Fund, which is available for payments to physicians and initiatives to improve quality. That fund may be used to offset part of the rate reduction anticipated for 2008, but there is no explicit requirement in the law to do so. CBO assumes that the amount in the fund will be spent to enhance payments to physicians in 2008 but has made no explicit assumptions about exactly how it will be spent. Therefore, CBO's estimates of the cost of proposed changes to payment rates do not include any effect from spending from the fund. If, in the future, CMS announces that it plans to use the fund to help offset the 2008 rate reduction, CBO will incorporate that information into its estimates of the budgetary impact of proposed changes in rates.

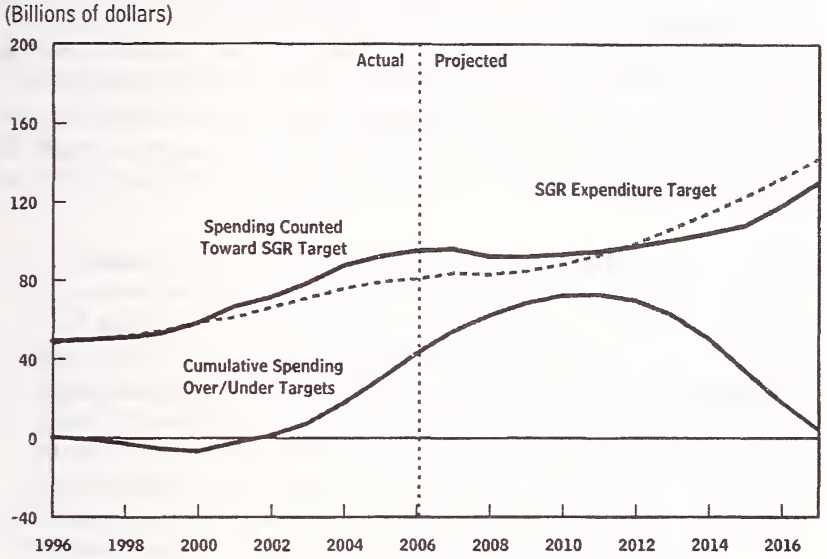
Projected Spending for Physicians' Services

Looking forward, CBO projects that spending for physicians' services will continue to exceed the cumulative target for the next several years. If the SGR method is not modified again, it will reduce payment rates beginning in 2008 and will keep updates below inflation through at least 2015.

Because of the impending reductions in payment rates required under current law, Medicare spending on services provided by physicians is projected to grow relatively slowly for the next several years. CBO estimates that the decline in payment rates will be slightly more than offset by increases in enrollment and growth in the volume and intensity of services being delivered. As a result, CBO projects, Medicare spending on physicians' services will grow in coming years but in 2017 will be only 10 percent higher than it was in 2006, reflecting an average annual growth rate of about 1 percent. In contrast, from 1997 through 2006, such spending grew by an average of about 7.1 percent annually.

Figure 2.

Sustainable Growth Rate Spending Compared with Expenditure Targets



Source: Congressional Budget Office.

Note: SGR = sustainable growth rate.

From 1997 through 2001, cumulative spending governed by the SGR mechanism was slightly below the expenditure target set by the formula (see Figure 2). Starting in 2002, cumulative spending rose above the cumulative target. According to CBO's projections through 2017, if the current SGR mechanism is permitted to operate, the cumulative deficit will continue to grow for several more years but will then decline as the annual growth in spending is slowed by the reductions in payment rates called for by the SGR mechanism. Toward the end of the period, CBO's projections show cumulative spending coming close to the cumulative target. The SGR mechanism is designed in such a way so that if viewed over a long enough period of time, cumulative spending will equal the cumulative target.

Budgetary Implications of Changing the SGR

The Congress has a wide range of options for changing or replacing the SGR mechanism. In any such decision, an important question is whether payment rates in the future should be reduced to recoup the spending exceeding the SGR targets that has already occurred, along with any future spending above the targeted amounts. This testimony presents estimates for three illustrative examples, includ-

ing fully replacing the SGR targets with annual updates based on inflation. (The appendix includes estimates for a number of other options.) Each policy option would increase payments for physicians' services relative to those that would be made under current law, as well as payments that the government makes for beneficiaries enrolled in Medicare Advantage.[9] The policies would also increase beneficiaries' out-of-pocket costs because a 20 percent copayment is required for each service provided by a physician and premiums from beneficiaries finance about one-quarter of Part B's total cost. The budget estimates reflect all three of those effects. (The figures included below, however, focus solely on the gross changes in spending for physicians' services, not the net budgetary impact including all three effects.)

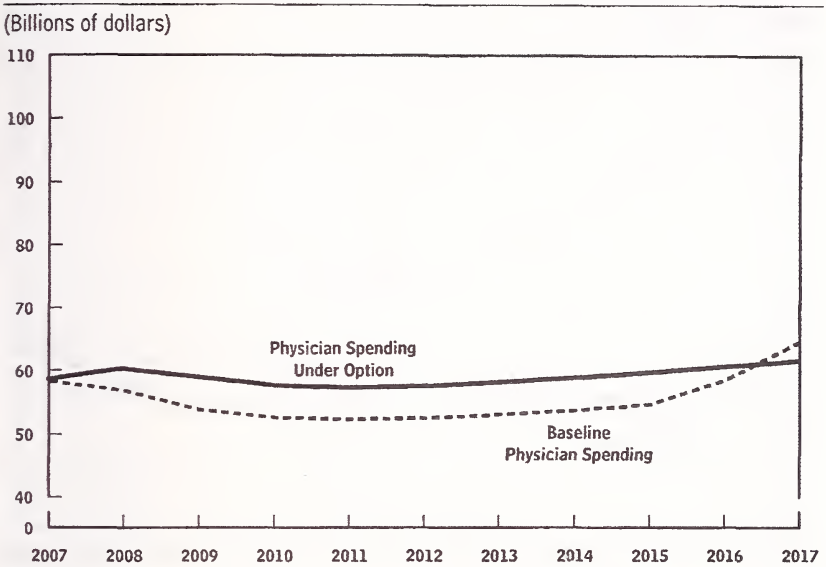
Option 1: Freeze payment rates in 2008 and allow the SGR formula to determine updates in subsequent years. This option would override the scheduled update for 2008 and hold overall payment rates under the physician fee schedule constant that year. In 2009 and subsequent years, payment rates would be determined by the SGR formula, under which the maximum adjustment factor of -7 percent would apply. In addition, if that action was not considered a change in law or regulation, the SGR expenditure targets would remain the same, and the difference between cumulative spending and the cumulative expenditure targets would be larger than is estimated under current law. Thus, the increase in spending attributed to the higher payment rate would eventually be recouped by the SGR mechanism, causing payment rates to be lower in the future than they would otherwise have been. Because the maximum adjustment factor is projected to apply for the much of the next 10 years, recouping the costs of this option would begin after that period has ended. This option is similar to what was enacted as part of the Deficit Reduction Act in 2006.

Spending for physicians' services under this option would be higher through 2016 and lower in subsequent years than the amount projected under current law (see Figure 3). According to CBO's estimates, this option would increase net federal outlays by $22 billion over the 2008–2012 period and by $34 billion over the 2008–2017 period. Under this option, spending per beneficiary would be about 5 percent lower in 2017 than it would be under current law.

9. Any increase in spending for physicians' services would increase the "benchmarks" that Medicare uses to determine how much the program pays for beneficiaries in the Medicare Advantage program. At the same time, about one-quarter of the changes in spending for physicians' services and for Medicare Advantage would be offset by changes in receipts from premiums that beneficiaries paid the government. However, legislation could specify that Part B premiums not be adjusted to reflect changes in spending resulting from changes in payment rates for physicians' services. Such a "premium hold-harmless" provision would increase federal costs by about 30 percent. The appendix includes estimates for several options that include such a provision.

Figure 3.

Spending on Physicians' Services If Payment Rates Are Frozen in 2008 and the Sustainable Growth Rate Determines Subsequent Updates



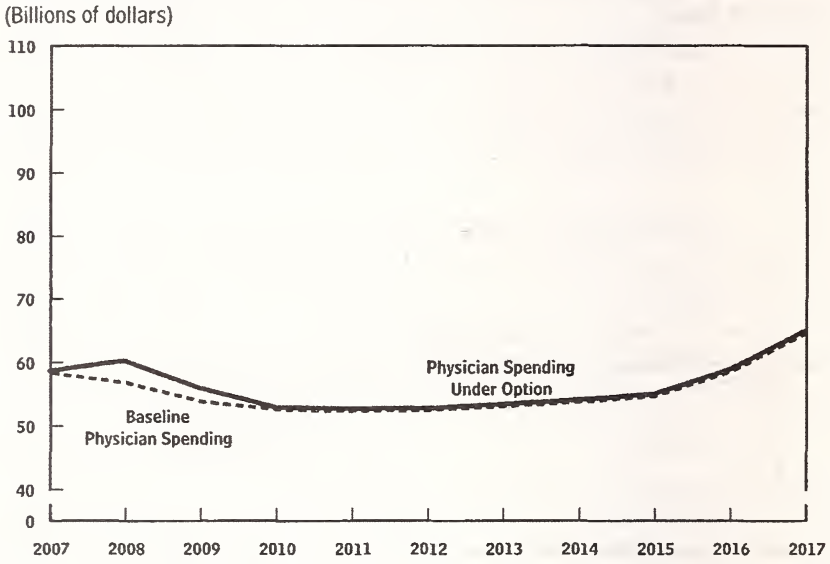
Source: Congressional Budget Office.

Option 2: Freeze payment rates in 2008 and set payment rates in 2009 and beyond at the levels the SGR formula would specify under current law. This option would override the update adjustment factor during 2008 and freeze overall payment rates that year. In 2009 and beyond, it would hold payment rates at their current-law levels, thus allowing rates to be reduced in 2009 by more than would be allowed under the SGR formula—around 15 percent that year. If that action was considered a change in law or regulation, the SGR would be adjusted to account for the increased payment rate, and the difference between cumulative spending and the cumulative target would be largely unchanged from that under current law. Spending increases resulting from this option would not be recouped by the SGR mechanism. This option is similar to what was enacted as part of the Tax Relief and Health Care Act of 2006.

Spending for physicians' services under this option would be higher than under current law for one calendar year (thus affecting two fiscal years) (see Figure 4). By CBO's estimates, this option would increase net federal outlays by $4 billion over the 2008–2009 period. Under this option, spending per beneficiary would be the same in 2017 as it would be under current law.

Figure 4.

Spending on Physicians' Services If Payment Rates Are Frozen in 2008 and Subsequent Rates Are Held at Current-Law Levels



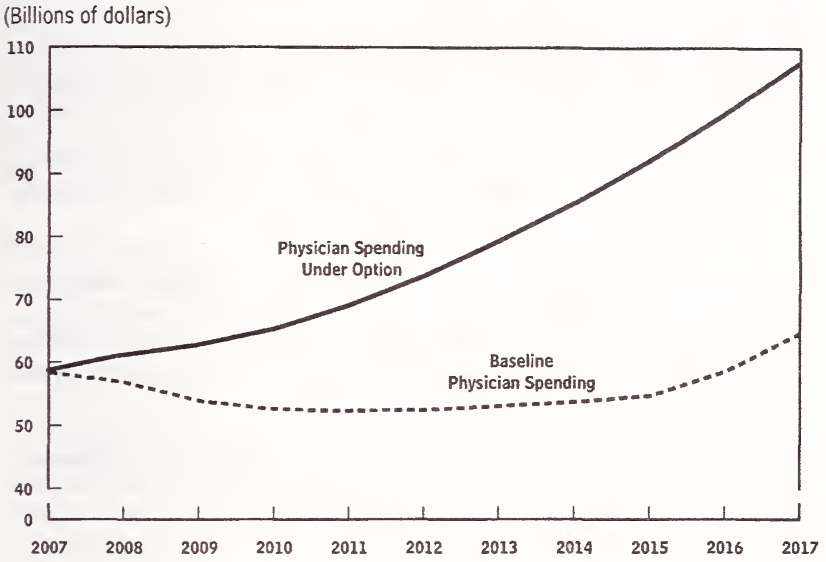
Source: Congressional Budget Office.

Option 3: Allow payment rates to increase by medical inflation. This option would repeal the current SGR mechanism and increase payment rates each year by the Medicare economic index. Instead of being reduced by approximately 10 percent in 2008 and about 5 percent annually for several years after that, payment rates would increase by around 2 percent annually. Those updates would not be subject to further adjustments, and spending increases would not be recouped.

Spending for physicians' services under this option would grow at an average annual rate of about 6 percent over the next 10 years, CBO estimates, compared with a 1 percent increase projected under current law. According to CBO's estimates, this option would increase net federal outlays by $65 billion over the 2008-2012 period and by $262 billion over the 2008–2017 period. Under this option, spending per beneficiary would be about 65 percent higher in 2017 than it would be under current law (see Figure 5).

Figure 5.

Spending on Physicians' Services with the Sustainable Growth Rate Replaced by Updates Based on the Medicare Economic Index



Source: Congressional Budget Office.

Potential Responses to Lower Payment Rates

In evaluating the SGR mechanism and potential changes to it, it is important to realize that significant reductions in payment rates for physicians' services could elicit changes in the behavior of both Medicare beneficiaries and physicians, affecting the volume and intensity of services that are provided. Beneficiaries, for example, who generally pay 20 percent of approved charges for covered services, could seek more (or more intensive) services if prices drop. However, because the vast majority of beneficiaries have supplemental insurance coverage (through a former employer, a medigap plan, or Medicaid) that insulates them from changes in the prices of Part B services, their response to such changes is likely to be small.

Physicians could respond to changes in payment rates in a number of ways. If Medicare's rates are reduced sufficiently, physicians could choose not to participate in the Part B program. At present, more than 90 percent of physicians and other providers have agreed to participate in Part B, and surveys generally show that beneficiaries have not faced significant difficulties in getting access to care.

That situation could change, however, if future payment rates are significantly reduced—as will occur if the SGR mechanism operates as currently specified in law.

Physicians could also respond to changes in payment rates by adjusting the supply of services they provide. Different models yield different predictions about how physicians would respond to a reduction in fees:

- Under a standard economic model in which physicians and physician groups maximize profits, a decline in the fees paid by Medicare would be predicted to lead to a decline in the quantity of services provided to Medicare beneficiaries.

- Under an alternative theory, physicians (through their recommendations about what treatments patients receive) respond to lower fees by inducing demand for their services to replace some or all of their lost income.

- Under a third method, physicians' responses are the net effect of two forces. A reduction in fees would, on the one hand, encourage physicians to do more work as a way to cushion their loss of income and would, on the other hand, encourage them to either shift to serving other types of patients or spend less time working—yielding a net effect that is ambiguous.

Much of the empirical work on the issue has examined changes in fees affecting limited types of services or procedures occurring over a short time span. That literature, which is limited in scope, has found both increases and decreases in the volume of services in response to fee reductions.

In contrast, broader studies focusing on changes in fees over longer periods and affecting all physicians tend to find an inverse relationship between changes in fees and volume—so when fees decline, volume increases. Those broader empirical studies, which are more useful for estimating the overall effects of fee changes in Medicare, tend to find that physicians respond to fee reductions by increasing volume and intensity, with elasticities of about -0.2.[10] In other words, a 1 percent reduction in fees would lead to a 0.2 percent increase in the volume or intensity of services that are provided—so spending would decline by about 0.8 percent instead of 1 percent.

CBO is currently examining the literature on physicians' responses to changes in fees and undertaking an empirical analysis of Medicare's experiences during the time period when the SGR mechanism has been in effect. The preliminary results, which are currently being reviewed, are in line with the previous literature. Note

10. See Stephen Zuckerman and others, "Price Controls and Medicare Spending: Assessing the Volume Offset Assumption," *Medical Care Research and Review*, vol. 55, no. 4 (December 1998), pp. 457–483; and Memorandum from the Volume-and-Intensity Response Team, Health Care Financing Administration, Office of the Actuary, to Richard S. Foster, Chief Actuary, "Physician Volume and Intensity Response," August 13, 1998.

that behavioral reactions by physicians to fee changes are over and above an underlying trend (during the period when the SGR has been in effect) in which the volume and intensity of services have grown at an average of about 4.5 percent per year.

That type of response by physicians to changes in payment rates does not explicitly affect CBO's projections of spending on physicians' services over the long term because under the SGR mechanism, payment rates will automatically adjust to offset the effects of changes in volume and intensity. Thus, total costs will be governed by the SGR formula, but the nature of physicians' responses will affect the availability of services to Medicare beneficiaries, the intensity of utilization of those services, and the prices charged for them.

Encouraging Efficient Medical Practice

Options for changing the SGR mechanism raise the broader possibility of moving the health system toward delivering better-value health care, which is an essential step toward putting the nation on a sound long-term fiscal path. If over roughly the next four decades, growth in health care costs per beneficiary continues to exceed growth in gross domestic product per capita by the same amount as over the past four decades, Medicare and the federal share of Medicaid will reach 20 percent of GDP in 2050, up from 4.5 percent today (as illustrated in Figure 1).

Better value could come from obtaining the same health outcomes at a lower cost or from better outcomes at currently projected spending levels. The first effect would directly improve the nation's projected fiscal imbalance. The second effect would mean that the revenues used to finance health programs were being put to more effective use.

Improving the quality of care provided through the health system will require changes in incentives. Recent initiatives, for example, aim to provide higher payments to those physicians who comply with "best practice" guidelines and other measures of quality. Medicare is introducing a voluntary reporting program that will collect quality measures for certain physicians' services. That program, under the Tax Relief and Health Care Act, is slated to begin in July 2007 and could be a foundation for future initiatives aimed at improving the quality of care under Medicare. CMS is also operating demonstration programs that link payments to the quality of care delivered to Medicare beneficiaries. Findings from those programs will provide valuable information about which paths are better suited to increase the value of the program.

The Congress could also lay the groundwork for other changes designed to discourage overuse of care under Medicare's fee-for-service method for compensating physicians—shifting the system toward payments tied to quality or efficiency. For example, doctors could be required or encouraged to participate in a system that evaluated usage patterns and provided feedback to individual doctors on their

practice patterns relative to their peers'. Another option involves grouping physicians into multispecialty units that would share some financial responsibility with Medicare for the utilization of care by patients served by the group. Some proposals envision placing doctors in a virtual group based on the hospital that their patients use (or on some other criterion); utilization across groups could then be aggregated and compared, and incentives could be created for physicians to economize on the services provided.

Systems for shifting incentives toward higher-value care require two changes to the underlying health infrastructure. The first is an information infrastructure to collect data on patients' conditions, the services ordered by physicians, and health outcomes and to distribute information back to individual doctors or groups. The second is an adequately funded effort, whether inside the government or outside it, to analyze the data, evaluate comparative effectiveness, and perhaps design and implement payment systems that reward the more efficient practice of medicine. The Congressional Budget Office will be examining both of those key steps in future reports. Even with such systems in place, shifting the incentives for providers will necessarily be an iterative process, in which both innovative medical interventions and payment mechanisms are tried, evaluated, and recalibrated.

In addition to creating the necessary infrastructure and altering incentives for providers, financial incentives could be changed for consumers. Despite the fact that Medicare's fee-for-service benefit package includes a deductible and 20 percent copayments for physicians' services, the vast majority of Medicare patients do not face those payments because they have some form of supplemental coverage. Such coverage reduces or eliminates incentives to weigh the cost of services against their potential benefits. CBO's 2007 *Budget Options* volume, which was released last Friday, includes an analysis of proposals that would decrease federal outlays by limiting the extent of such supplemental coverage and by making other changes in the cost-sharing requirements of Medicare's fee-for-service program, including the addition of catastrophic protection.

Appendix: Budgetary Effects of Alternative Proposals for Medicare's Payments for Physicians' Services

Table A-1.

Estimated Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates, Fiscal Years 2008 to 2017

(Billions of dollars)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
Freeze Payment Rates in 2008 and Hold Future Rates at Current-Law Levels	2.5	1.7	0	0	0	0	0	0	0	0	4.2	4.2
Freeze Payment Rates in 2008 and 2009 and Hold Future Rates at Current-Law Levels	2.5	6.3	2.5	0	0	0	0	0	0	0	11.4	11.4
0 Percent Update in 2008	2.5	4.8	4.8	4.8	4.8	4.9	4.9	4.8	1.7	-3.6	21.7	34.4
0 Percent Update in 2008 and Premium Hold-Harmless	3.2	6.1	6.1	6.1	6.2	6.3	6.3	6.1	2.2	-4.6	27.7	44.1
0 Percent Update in 2008 and 2009	2.5	6.3	7.2	7.2	7.3	7.4	7.5	7.4	4.4	-0.9	30.6	56.2
0 Percent Update in 2008 and 2009 and Premium Hold-Harmless	3.2	8.1	9.2	9.3	9.4	9.5	9.6	9.4	5.6	-1.2	39.2	72.1
1 Percent Update in 2008	2.8	5.3	5.3	5.3	5.3	5.4	5.5	5.3	2.3	-3.1	23.9	39.3
1 Percent Update in 2008 and Premium Hold-Harmless	3.6	6.8	6.7	6.8	6.8	6.9	7.0	6.8	2.9	-3.9	30.6	50.4
1 Percent Update in 2008 and 2009	2.8	7.2	8.2	8.3	8.4	8.5	8.6	8.4	5.5	0.2	34.9	66.0
MEI Update in 2008	3.2	6.0	6.0	6.0	6.1	6.1	6.2	6.1	3.0	-2.3	27.2	46.4
MEI Update in 2008 and 2009	3.2	8.4	9.8	9.8	9.9	10.0	10.2	10.1	7.1	1.9	41.1	80.3

Continued

Table 1.

Continued

(Billions of dollars)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
"Reset" SGR Targets at 2007 Spending Level[a]	3.2	8.0	10.4	12.6	15.1	18.7	23.3	29.0	32.0	32.6	49.2	184.8
Freeze Physician Payment Rates at 2007 Level Through at Least 2017	2.5	6.5	9.4	12.6	15.9	19.6	23.7	28.4	29.9	28.9	46.9	177.4
Automatic MEI Update (Replace SGR)	3.2	8.7	12.9	17.6	22.6	28.1	34.3	41.4	45.7	47.7	65.0	262.1
Automatic MEI Update (Replace SGR) and Premium Hold-Harmless	4.1	11.1	16.4	22.3	28.6	35.5	43.3	52.1	57.3	59.8	82.4	330.5

Source: Congressional Budget Office.

Notes: Estimates are based on the Congressional Budget Office's March 2007 baseline.

MEI = Medicare economic index; MA = Medicare Advantage; SGR = sustainable growth rate.

Except for the first two and last three options, estimates assume that the normal SGR mechanism would apply after the specified period. The first two options would allow for a larger reduction in payment rates than would otherwise be permitted by the SGR formula. In addition, increases in spending resulting from those two options would be considered a change in law or regulation and would not be subject to being recouped by the SGR mechanism. The other options except the last three would not be considered a change in law or regulation, so increases in spending would be subject to be being recouped by the SGR mechanism.

Proposals that include a "premium hold-harmless" provision would exclude increases or decreases in spending attributable to them from calculations of the Part B premium.

a. This option would forgive all spending that has accrued above the cumulative targets and set both the cumulative target and cumulative spending to zero as of December 31, 2006, using calendar year 2007 as the base period for future application of the SGR mechanism.

Responses by Peter R. Orszag to Questions for the Record for the Senate Finance Committee's Hearing Medicare Payment for Physician Services: Examining New Approaches March 1, 2007

Questions from Chairman Baucus

Question. Why does the growth in physician spending vary so dramatically across geographical regions?

Answer. Most of the research into geographic variation in health spending has focused on differences across regions in the levels of spending, rather than differences in growth rates. There is a great deal of geographic variation in health care spending, and in Medicare physician spending in particular. In 2004, Medicare expenditures per beneficiary for physician and laboratory services ranged from under $1,400 in Hawaii to over $2,900 in Florida. When the authors of the Dartmouth Atlas of Health Care examined reasons for geographic variation in Medicare spending per beneficiary, their analysis (which was not limited to spending on physicians' services) showed that only a relatively small part of the variation derived from the things we would expect, like demographics, illness, and local practice costs. In addition, they found, differences in the availability of medical resources contributed to the variation in spending, in particular the supply of hospital beds and specialist physicians. Because of the ongoing interest in the general topic of geographic variations in health spending, the Congressional Budget Office (CBO) is continuing to investigate this issue.

Question. Isn't it true that some research suggests reducing physician payments, as a target-based system would, only encourages inefficiency and higher volume?

Answer. Evidence exists that supports the notion that physicians respond to fee cuts by increasing the volume or intensity of the services they provide. CBO is currently examining this issue and its findings are in line with the previous empirical literature. Research indicates that any increased volume due to a behavioral response to a reduction in fees would not be large enough to generate a net increase in total spending; instead, the increased volume would slightly offset the decline in spending that follows from the reduction in fees.

Question. Wouldn't it be best to implement reforms "ground up" to change the incentives of the payment system rather than impose a "top down" target on spending?

Answer. In principle, a "ground-up" approach may be better suited to offer appropriate incentives for physicians to provide efficient medical care. However, designing that type of reform requires specifying and reaching consensus on a large number of specific details about the desired payment system.

One advantage of a "top down" approach, such as the Sustainable Growth Rate, is that it can maintain budget discipline by automatically limiting the growth in Medicare's spending for physicians' services unless the Congress acts to modify the mechanism. On the other hand, as it has been noted repeatedly, that approach does not provide individual physicians with incentives to provide efficient medical care.

Question. Which of the "value-improving" options presented by MedPAC are ready to be implemented this year? Which will be most effective in incentivizing more efficient, higher quality care?

Answer. To date, the Congressional Budget Office has not examined those options in detail.

Question. What kind of impact can we expect the "value-improving" options for reform to have on overall physician spending?

Answer. The impact of "value-improving" options on physician spending depends on the details of the actual legislation. Better value could come from obtaining the same health outcomes at lower levels of spending or better health outcomes at the currently projected level of spending.

Question from Senator Bunning

Question. The second pathway suggested by MedPAC would replace the current physician formula with a new formula of expenditure targets and expand it to all providers under fee-for-service, among other things. The current physician formula hasn't worked well. What are the risks—or benefits—in using the same type of reimbursement system for all providers?

Answer. A benefit of applying a single expenditure target for all Medicare providers is that it would recognize that the projected growth in Medicare expenditures is not solely attributable to spending for physicians' services but to that for all of the Medicare providers. As with the SGR, however, an expenditure target by itself does not provide the appropriate incentives for obtaining more efficient medical care.

Questions from Senator Stabenow

Question. MedPAC's *Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System* (March 1, 2007) does not make specific recommendations. Does Congress have the information we need to move forward with a new payment system at this point? If not, what other information do we need?

Answer. The information required to move forward with a new payment system depends on the objectives of that system. The Congress does not yet have sufficient information, for example, to shift the physician payment system from fee-for-service to one that focuses on the value provided by different treatments and technologies. (CBO is

expanding its health activities in part to help provide Congress with this type of information.) On the other hand, Congress probably does have sufficient information to change the payment system along the lines of the options provided in the Appendix to my written testimony.

Question. How can we determine whether the volume of physician services currently being provided, and projected under different payment systems, is appropriate or inappropriate?

Answer. The task of determining whether medical care is appropriate or inappropriate is a challenging one. Although some medical diagnoses require standardized care for which consensus on the treatment protocol, other conditions involve less uniform treatment practices. In research that RAND conducted on 30 medical conditions, Medicare enrollees received the recommended care in only about 60 percent of cases.[1] Disparities in Medicare spending across geographic regions unrelated to better care, improved quality, or better health outcomes also suggests that some of the existing level of medical care may be inappropriate.

Many analysts have highlighted the potential benefits from assessing the "comparative effectiveness" of health care treatments. Under that approach, the benefits, risks, and costs of one treatment option are compared to those for other options—be they drugs, devices, procedures, or diagnostics. CBO is preparing an initial report on this topic and will follow up with more information as it is developed.

Question. The returns of health IT accrue to payers and patients, but providers must pay for the acquisition and implementation of these systems—which can be very expensive. How can the federal government encourage adoption of health information technology by Medicare providers?

Answer. The federal government could encourage the adoption of health IT in a number of ways: encouraging the development of a standardized structure for health IT information, subsidizing the purchase and use of IT systems, paying providers differentially depending on their use of approved systems, or helping in the development of a structure that would address privacy concerns about information on patients. It should be noted that providers can also benefit from health IT. Some of the gains to providers include paperless records, access to current treatment guidelines, improved communication and collaboration among providers, and options to increase telemedicine. However, the construction of an IT infrastructure will not, by itself, necessarily lead to more efficient medical practices or slower growth in spending. Incentives for providers and consumers will play a crucial role in whether IT leads to more efficient use of health care resources.

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[1] RAND Health, "The First National Report Card on Quality of Health Care in America," Research Brief RB-9053-2, 2006.

Question. Many members of Congress have urged the Administration to remove Part B drugs from the SGR formula. CBO, in the *Budget Options* document, stated that permanently replacing the SGR with MEI updates would cost $65 billion over 5 years and approximately $262 billion over 10 years.

If the Administration were to remove the cost of these drugs from the SGR formula retroactively, how much would this reduce the legislative cost of replacing the SGR with MEI updates over 1 year, 5 years, and 10 years?

Answer. Retrospectively removing physician-administered drugs from the SGR mechanism would involve removing all spending for physician-administered Part B drugs that was counted under the mechanism going back to its "base period" of April 1, 1996, to March 31, 1997. Spending on drugs would also be removed prospectively, in that future spending on Part B drugs would not be counted under the SGR mechanism. In order to maintain parallel treatment within the SGR, the annual sustainable growth rate would be recalculated from the base period forward so as not to include price growth for Part B drugs.

CBO estimates that retrospective removal of spending for drugs from the SGR mechanism would have no effect on net Medicare spending in 2008 but would increase Medicare spending by $11 billion over the 2008–2012 period and by $105 billion over the 2008–2017 period. The approach would not change spending in 2008 because it would reduce, but not eliminate, the amount by which cumulative spending exceeds the cumulative SGR target. Therefore, CBO projects that the SGR mechanism would still result in several years of maximum negative updates to physicians' fees before any positive updates would occur.

Replacing the SGR mechanism with updates based on the Medicare economic index (MEI) would increase net Medicare spending by $3 billion in 2008, $65 billion over the 2008–2012 period, and $262 billion over the 2008–2017 period, CBO estimates.

The cost of combining both replacement of the SGR with updates based on the MEI and retrospective removal of Part B drugs from the SGR mechanism would be identical to the cost of simply implementing MEI updates: an estimated increase in Medicare spending of $3 billion in 2008, $65 billion over the 2008–2012 period, and $262 billion over the 2008–2017 period.

However, if (1) physician-administered drugs were removed retrospectively from the SGR mechanism and (2) subsequent legislation enacted MEI updates (with both changes effective beginning in 2008), the estimated increase in Medicare spending for those changes would be:

- zero in 2008, $11 billion over the 2008–2012 period, and $105 billion over the 2008–2017 period for the first action and
- $3 billion in 2008, $55 billion over the 2008–2012 period and $157 billion over the 2008–2017 period for the second.

TESTIMONY BEFORE THE

SENATE FINANCE COMMITTEE

ON

MEDICARE PAYMENT OF PHYSICIAN SERVICES

March 1, 2007

WASHINGTON, D.C.

WITNESS: BYRON THAMES, MD
AARP BOARD MEMBER

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Chairman Baucus, Ranking Member Grassley, and members of the committee, my name is Byron Thames. I am a member of AARP's Board of Directors and a physician. Thank you for inviting AARP to testify on reforms to Medicare's payment for physician services.

AARP believes that physicians are central to the delivery of health care, and that Medicare's payment system should encourage quality and affordable care. Today's hearing focuses on the sustainable growth rate (SGR) system, which has been widely recognized as flawed. The SGR does not distinguish between those doctors who provide Medicare beneficiaries with high quality care and those who provide unnecessary or inappropriate services. Moreover, the SGR has not been effective at controlling the volume or intensity of services, which has led to higher Medicare spending and greater out-of-pocket costs for beneficiaries.

AARP believes that ultimately the SGR should be replaced with a system that encourages physicians to provide beneficiaries and the Medicare program with greater value for the health care dollar. Medicare beneficiaries need and expect their doctors to provide effective treatment. Payment incentives should encourage high quality, not unnecessary quantity. A truly sustainable payment system will be built on a foundation that emphasizes four key elements: information technology; greater use of comparative effectiveness research;

performance measurement including physician resource use; and enhanced care coordination.

The Doctor-Patient Relationship: What AARP Members Say

AARP recently conducted a survey asking older Americans – current and future Medicare beneficiaries – about their experience with physicians. The vast majority of those surveyed report good access to and high levels of satisfaction with their physicians, but the cost of care remains a concern for people.

Medicare beneficiaries are beginning to feel the impact of the large Part B premium increases caused, in part, by the many legislative changes that have overridden the SGR. Of those surveyed, fourteen percent of beneficiaries said that they had to give up something to pay for an increase in their Medicare premium. Twenty one percent said they had to cut back on groceries.

The AARP members surveyed are among the over 43 million Americans who rely on Medicare for their health care. Physicians are central to the delivery of that health care. AARP believes physicians who treat Medicare patients should be paid fairly. But as we have learned from our members, the program must be affordable for beneficiaries as well. Determining how to balance these two needs is a complex, yet critical, policy problem that must be solved for the Medicare program to remain strong for future generations.

AARP supports long-term reform of the physician payment system. Annual short-term fixes simply exacerbate spending growth and only delay needed discussions about how to control rising expenditures. AARP believes the time has come to move toward a payment system that rewards physicians for providing greater value for health care spending. A recent Institute of Medicine report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, concluded that "because the current basic payment systems reward overuse of services, use of high-cost complex procedures, and do not acknowledge the wide variations in quality across providers, . . . payment reforms are needed now to recognize care that is of high clinical quality, patient-centered, and efficient."

We couldn't agree more. All Medicare beneficiaries must have access to physicians who provide high quality care. At the same time, beneficiaries need to be protected from extraordinary out-of-pocket costs.

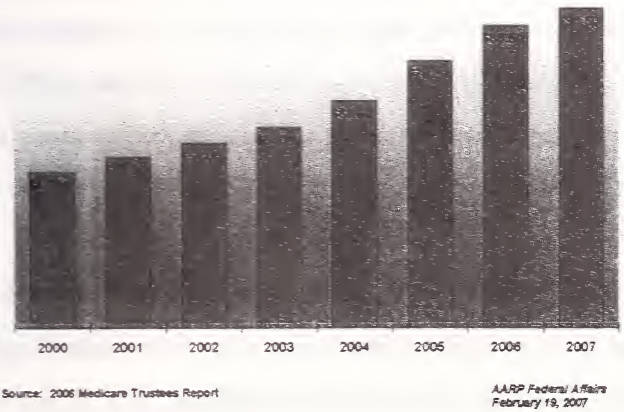
Overriding the SGR: Direct Financial Consequences for Beneficiaries

The SGR system, designed to keep spending in line with an overall target, was viewed as necessary to address unchecked increases in the volume of physician services. Since 2002, actual spending on physician services has exceeded the SGR target, thereby triggering reductions in physician updates. With the

exception of 2002, however, Congress has consistently voted to override this mandated reduction in response to physician concerns.

Unfortunately, each time Congress overrides the SGR there is a direct cost for Medicare beneficiaries. That's because by law, the monthly Medicare Part B premium is set at 25 percent of Part B spending. The Part B premium has doubled since 2000 – due in part to the payment increases for physicians (see chart).

Part B Premiums More than Double Since 2000



Source: 2006 Medicare Trustees Report

AARP Federal Affairs
February 19, 2007

Beneficiaries again face large increases in their 2008 premiums due to a convergence of three factors. First, the congressional action taken late last year to avert a physician pay cut in 2007 will not affect the beneficiary Part B premium until next year because the 2007 premium had already been calculated. Second,

other factors will put additional upward pressure on Part B premium cost growth for 2008 (e.g., growth in Medicare outpatient spending, expenditures for physician-administered drugs, and Medicare Advantage payments, which exceed costs in traditional Medicare by approximately 12 percent, on average). Third, if Congress acts again this year to prevent a reduction in physician payments – estimated by the Congressional Budget Office at 10 percent – these additional costs could also be rolled into the 2008 beneficiary premium.

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare's payment – also jump each time provider reimbursement rates increase. For each increase of $10 billion in physician payments, beneficiary coinsurance amounts increase roughly $2 billion. In addition, the increased Part B spending also leads directly to a higher Part B deductible. Since 2005, the annual deductible has increased along with per capita Part B expenditures.

The Medicare program must be kept affordable to remain true to its intent. When it was created in 1965, more than half of older Americans were uninsured and they were the population most likely to be living in poverty. Today, about 50 percent of Medicare beneficiaries have incomes below $15,000, and the median income for an individual between the ages of 65 and 69 is less than $30,000. The average older person already spends about one quarter of his/her income on health care. This does not include the additional, and often substantial, costs of

services that Medicare does not cover – including long-term home and nursing home care. If Part B premiums and cost-sharing continue to escalate, many more beneficiaries will find it increasingly difficult to pay for the care they need.

Each time the SGR is overridden, the price tag beneficiaries pay in the long run increases. Due to the cumulative nature of the targets, physician payment updates in future years must be lowered to offset the accumulated excess spending and to slow expected spending for the coming year. As a result, under the SGR methodology, physician fees are expected to be reduced each year at least until 2012. Under this scenario, we can expect to continue the now annual cycle of physician groups lobbying Congress to avoid these payment cuts, doctors threatening to stop taking Medicare patients, and Congress overriding the SGR at the last minute. We must find a better approach.

Alternatives to the SGR: MedPAC's Report to Congress

Today, MedPAC releases a new report that examines alternatives to the current SGR. The Senate Finance Committee asked AARP to respond to this report. As requested by Congress, MedPAC studied the implications of moving from a single, national SGR to five potential sub-national target systems that would be based on: geography, type of service, group practice, hospital medical staff, and outliers. We commend MedPAC for providing a thorough examination of each alternative's advantages and disadvantages.

From the beneficiary perspective, we believe the outlier option holds the most promise for higher quality at a lower cost to the Medicare program. One of the major advantages of the outlier approach is that it would allow the Medicare program and others to learn from those physicians who use fewer resources while maintaining a high level of quality. It is important to better understand the differences between inappropriate volume growth and appropriate growth (e.g., from technology changes that improve care for patients). This information could be used to identify best practices for the treatment of specified patients and conditions. An outlier policy could also promote individual physician accountability. It does not require a large scale restructuring of the existing physician marketplace and could be used to measure most physicians in the United States.

Similarly, as MedPAC notes, encouraging specific actions, such as care coordination or investment in information technology, may be more successful than varying reimbursement levels based on a physician's specialty, or region, or practice type.

MedPAC presents two alternative paths for Congress to consider for paying physicians in the Medicare program. The first path would be to repeal the SGR and pursue policy approaches for improving the value of the Medicare physician

payment system. The second path would be to retain some type of expenditure target – applied to all Medicare providers, calculated at a geographic level.

Medicare's experience with the SGR has not proven to be successful and beneficiaries have borne the financial penalty in higher out-of-pocket-costs. As MedPAC noted, it is a flawed system that inappropriately influences clinical decisions about where and how many services are provided.

Clearly, the SGR has not been effective at controlling the volume of physician services. According to the Government Accountability Office, from 2000-2005, while Medicare physician fees rose by 4.5 percent, program spending on physician services grew by nearly 60 percent. On a per beneficiary basis, spending for physician services grew by approximately 45 percent.

Many experts have concluded that one of the SGR system's fundamental flaws is its assumption that physicians would act collectively – on a national level – to control the volume of service. MedPAC concluded in 2002 that, "if anything, an individual physician has an incentive to increase volume under such a system."

The SGR does not distinguish between those doctors who provide high quality care to beneficiaries and those who provide unnecessary services. In fact, physicians providing the most efficient care are penalized under Medicare's

current payment system while a physician who orders more tests or performs more procedures than are indicated is paid more.

The volume performance standard, which was used to set Medicare fee updates from 1992-1997, was eliminated because of concerns about how it distorted payments for one service relative to another. It is not clear that a new form of expenditure target will be any better for beneficiaries or Medicare, and another administratively-complex formula could lead us down yet another time-consuming and failed path of unintended consequences. As MedPAC warns in its executive summary, "the risk that a formulaic expenditure target will fail and have unintended consequences is substantial."

For these reasons, the first path outlined by MedPAC may have more promise. AARP believes Congress and CMS should focus their efforts on redesigning the payment incentives to promote quality and encourage efficiency. Congress should not abandon its emphasis on controlling expenditures, but it should put its energy into finding strategies that encourage better, more efficient, and patient-centered care.

There are a number of factors to consider. First, ultimately repealing the SGR would be quite costly. A transition to a value purchasing framework must not be financed at beneficiary expense. Therefore, some kind of transition may be necessary. Second, we need to make sure beneficiaries are protected from

extraordinary out-of-pocket expenses as the Part B payment system is reformed. One such protection would be a cap on Part B premium increases. Congress could stipulate that the Part B premium could only increase by a certain percentage, dollar amount, or a five-year average. While beneficiary premiums would still increase, the increases would be limited, and beneficiaries would be in a better position to plan their monthly expenses.

Another potential option is to limit total Part B out-of-pocket costs. Unlike many health insurance policies available to younger Americans, Medicare has no catastrophic limit for cost-sharing. Protecting sicker beneficiaries who are more vulnerable financially is critically important.

Third, elimination of the SGR cannot be viewed as carte blanche for physicians to maximize revenues through uncontrolled increases in the volume of services. The volume of unnecessary services in Medicare remains a problem – in terms of the quality of care provided, the added cost to beneficiaries, and the rate of growth in Medicare spending. A new physician payment system should be designed to encourage appropriate care and prevent unrestrained volume.

Congress cannot continue to avoid the current problem in the Part B payment system. The annual physician payment fixes Congress has enacted since 2003 have created an increasingly bigger hole which will become harder to climb out of

as each year passes. We believe the time to act is now. AARP stands ready to work with Congress and the physician community to develop a workable solution.

Changing the Incentives to Promote High Quality

AARP also believes Congress needs to change the incentives in Medicare's physician payment system to promote quality and encourage efficiency. We recommend Congress focus its efforts on four key areas: encouraging widespread adoption of health information technology; expanding the use of comparative effectiveness research; utilizing performance measurement including physician resource use; and enhancing care coordination.

Information Technology – AARP believes health information technology (HIT) has enormous potential to both improve quality and eventually lead to lower costs throughout our health care system. Yet the United States lags far behind most industrialized nations in maximizing its potential benefits. According to the Commonwealth Fund, only about one-fourth of U.S. primary care physicians report use of electronic medical records, compared with nine of ten primary care physicians in the Netherlands, New Zealand and the U.K.

Among the many advantages of HIT, it could: help providers coordinate care across settings, reduce errors and duplicative services, support clinical and patient decision making, improve communications between doctors and patients,

and help to foster patient management of their health conditions through ready access to their personal information. Finally, HIT could create "virtual" integrated delivery systems without requiring formal mergers or affiliations.

Expand Comparative Effectiveness Studies and the Clinical Evidence Base – Consumers, providers, and purchasers need objective, credible, evidence-based information to help them make good health care decisions. Congress recognized this need in section 1013 of the Medicare Modernization Act of 2003 by authorizing $50 million for head-to-head comparisons of treatment options. To date, the Agency for Healthcare Research and Quality (AHRQ) has received only $15 million for 2005 and $15 million for 2006 – far below the authorized amount. Congress should provide AHRQ, at a minimum, with $50 million in FY 2007 for comparative effectiveness research and begin to look at expanding the opportunities for both financing and using this research.

Comparative effectiveness research is a way to compare drugs within a therapeutic class, similar procedures, or drugs versus procedures to determine which treatments are most effective. In addition, as the MedPAC report notes, comparative effectiveness research could also be used to help "prioritize pay-for-performance measures, target screening programs, or prioritize disease management initiatives." This type of research could improve the overall quality of health care delivery and patient outcomes while reducing inappropriate, inefficient, and ineffective care. There is a clear need for a significant

government role in paying for this important evidence, since Medicare and other federal programs stand to benefit (over 40 percent of health care is paid by the federal government) from having a stronger base of evidence on which to make payment and other decisions.

Performance Measurement – We applaud Senators Baucus, Grassley and other members of the Committee for their hard work in ensuring that bonus incentive payments to physicians who report on quality measures were included for 2007. These quality reporting efforts begin to move Medicare in the important direction of providing better quality and more value for beneficiaries.

Pay-for-reporting represents a first step and the initial Centers for Medicare and Medicaid Services (CMS) list of quality measures for the Physician Voluntary Reporting Program – now referred to as the Physician Quality Reporting Initiative – is a starting point for a discussion. However, there is still substantial work to be done on the quality measures themselves so that when we actually pay-for-performance there will be rigor in the process to justify spending Medicare resources on this initiative.

For pay-for-performance to be successful in improving care for beneficiaries, AARP believes Medicare should focus first on high cost, highly prevalent conditions for which valid, reliable measures exist (such as for diabetes and congestive heart failure) as well as on efficiency and resource use and care

coordination. While it is important that all physicians participate in the program eventually, this should not be CMS's first priority. The top priority should be improving health care for Medicare beneficiaries and giving them value. Let's start with good measures that can effectively assess performance across the high priority areas that have been identified.

AARP believes that the federal government must financially support the development of performance measures. Improving health care should be considered a public good and we will not be able to improve quality unless we have valid and reliable measures to assess what we are doing. Measures should be vetted through an open forum with meaningful consumer input (such as the National Quality Forum).

There are many gaps in our ability to assess health care quality. These gaps must be filled as quickly as possible. We need to improve risk adjustment methods to remove any incentives doctors may have to avoid patients with multiple chronic conditions, or inadvertently penalize providers in underserved communities.

Performance assessment must include resource use and efficiency. Researchers at the Dartmouth Medical School have found that regions of the United States with the highest health care spending do not appear to have sicker patients or better outcomes than regions with lower spending. They estimate

that Medicare could reduce spending by at least 30 percent, while improving the outcomes of care, if the physicians whose practice styles are the most resource intensive (i.e., they order more diagnostic services and procedures) reduced the intensity of their practice. In its discussion of an outlier policy and measuring resources and providing feedback, MedPAC provides convincing arguments for why CMS should measure physicians' resource use over time and provide the results to physicians. AARP strongly recommends that CMS adopt this recommendation, especially if the SGR is eventually repealed. It is critically important that the Medicare program continue to focus efforts on ways to help physicians practice most appropriately. We would hope that the information could eventually be used to help beneficiaries identify those physicians who deliver high quality care. It could also eventually be used to help design payment policies.

Enhancing Care Coordination – Finally, we should focus again on the doctor-patient relationship, a relationship of great importance to most AARP members. Under Medicare's current physician payment system, physicians who conduct procedures receive higher compensation than those who diagnose and manage complex problems. Doctors who spend time with their patients and their family members to discuss treatment options are reimbursed at much lower rates. For example, the national average Medicare reimbursement for placement of two coronary artery stents via cardiac catherization was $1,012 in 2002; a two-hour family meeting was reimbursed on average between $75 and $95. It should be

noted that national comparisons conducted by Dartmouth researchers indicate that communities with more robust primary care provide lower cost, higher quality care. It is clear that the mix of physicians in a community has a direct impact on quality and cost. Moreover, patients report more care coordination problems the more specialists they see.

As the MedPAC report emphasizes, the Medicare program could improve the efficiency of health care delivery by increasing the use of primary care services and encouraging coordination of care. Coordination of care is important for individuals with multiple chronic conditions and especially as individuals move across care settings. AARP believes that Medicare's payment methods should be changed to create incentives in the fee-for-service system to better coordinate care so that beneficiaries receive the best care possible. In addition, other practitioners, such as nurse practitioners, physician assistants, and advanced practice nurses, might help fill this growing gap of primary care and needed care coordination.

Treatment of chronic illnesses accounts for the majority of health care expenditures, including those of the Medicare program, yet the traditional Medicare system is not designed to prevent complications. For example, a 2003 study by Elizabeth McGlynn of the quality of care delivered to adults in the U.S. found that only 24 percent of people with diabetes had their blood sugar appropriately monitored, and 45 percent of people presenting with myocardial

infarction received the proper medications known to reduce deaths among patients suffering from this condition. Medicare beneficiaries – whether they choose managed care or traditional Medicare – should have access to better chronic care management.

Recently enacted Medicare legislation has expanded the number and type of Medicare demonstration projects to examine the impact of various strategies for improving the coordination of care for beneficiaries with chronic conditions in traditional Medicare, such as the Medicare Health Support demonstration, the Physician Group Practice demonstration, and the new Medical Home demonstration.

AARP supports developing comprehensive, coordinated approaches to financing and delivering a wide range of needed care to chronically ill people. We hope to see effective strategies of this kind applied to the broader Medicare beneficiary population soon.

Conclusion

In conclusion, millions of AARP members depend upon Medicare every day. They need access to the best quality care and the physicians who deliver it. And they need that care to be affordable. The SGR system has not successfully controlled physician spending. To help keep Medicare affordable for beneficiaries today and financially strong into the future, AARP believes the

incentives in the current physician payment system need to be changed to promote quality and encourage efficiency. We look forward to working with you and your colleagues to address this challenge.

United States Senate Committee on Finance Hearing
Medicare Payment for Physician Services: Examining New Approaches
March 1, 2007

Questions Submitted for the Record for Dr. Byron Thames
Responses from AARP

Chairman Baucus:

Question for the Panel:
Why does the growth in physician spending vary so dramatically across geographical regions?

In its June 2003 report to Congress, the Medicare Payment Advisory Commission concluded that about 40 percent of the variation in per beneficiary Medicare spending is attributable to differences in health status, input prices, and special payments to hospitals (for example, indirect medical education payments). The remaining 60 percent of variation results from differences in the quantity and mix of services used, due to practice patterns, propensity to use services, and other factors, such as the supply of providers and availability of providers.

More recent research by Elliott Fisher, MD, and colleagues attributed differences in spending almost entirely to "supply-sensitive services": the frequency of visits to physicians, how much time similar patients spend in the hospital, and differences in other discretionary services such as imaging, diagnostic tests and minor procedures.

AARP believes there is still a lot to learn about these differences in spending. In its discussion of an outlier policy and measuring resources and providing feedback, MedPAC provides convincing arguments for why CMS should measure physicians' resource use over time and provide the results to physicians. AARP strongly recommends that CMS adopt this recommendation, especially if the SGR is eventually repealed. It is critically important that the Medicare program continue to focus efforts on ways to help physicians practice most appropriately. We would hope that the information

could eventually be used to help beneficiaries identify those physicians who deliver high quality care. It could also eventually be used to help design payment policies.

Question for all Witnesses:
Wouldn't it be best to implement reforms from "the ground up" to change the incentives of the payment system, rather than impose a "top down" target on spending?

Yes. Past experience with expenditure targets, such as the SGR and the volume performance standard, have proven to be unsuccessful. It is not clear that a new form of expenditure target will be any better for beneficiaries or Medicare, and another administratively-complex formula could lead us down yet another time-consuming and failed path of unintended consequences. As MedPAC warns in its executive summary, "the risk that a formulaic expenditure target will fail and have unintended consequences is substantial."

AARP believes Congress and CMS should focus their efforts on redesigning the payment incentives to promote quality and encourage efficiency while keeping the program affordable for beneficiaries. Congress should not abandon its emphasis on controlling expenditures, but it should put its energy into finding strategies that encourage better, more efficient, and patient-centered care.

Question for all Witnesses:
Which of the "value-improving" options presented by MedPAC are ready to be implemented this year? Which will be most effective in incentivizing more efficient, higher quality care?

AARP believes all of the "value-improving" options outlined by MedPAC hold promise. We believe the following are ready to be implemented this year:

- Measuring resource use and providing feedback;
- Improving program integrity;
- Encouraging the use of existing comparative-effectiveness information (we also believe that more work needs to be done in this area to expand the availability of research)

Of the others listed, we believe more work needs to be done before they can be implemented, however, we would prioritize them as follows:

- Encouraging coordination of care and the use of care management processes
- Using standards to ensure quality
- Linking payment to quality
- Promoting the use of primary care
- Bundling to reduce overuse
- Rethinking Medicare's cost-sharing structure

Question for Dr. Thames and Chairman Glenn Hackbarth:
Did your findings regarding beneficiary access to physician services distinguish between rural areas and urban ones? If so, could you please elaborate on those findings and comment on how this bodes for the long-term ability of Medicare beneficiaries in rural areas to have sufficient access to care?

AARP's survey did not distinguish between rural areas and urban areas.

Senator Bunning:

Question for the Panel:
The second pathway suggested by MedPAC would replace the current physician formula with a new formula of expenditure targets and expand it to all providers under fee-for-service, among other things. The current physician formula hasn't worked well. What are the risks – or benefits – in using the same type of reimbursement system for all providers?

Medicare's 43 million beneficiaries use thousands of different health care products and services furnished by over 1 million providers in hundreds of markets nationwide. Medicare pays for these services using 15 payment systems that are generally organized by delivery setting.

Medicare's experience with expenditure targets has not yet proven to be successful. It is not clear that a new form of expenditure target will be any better for beneficiaries or Medicare, and another administratively-complex formula could lead us down yet another time-consuming and failed path of unintended consequences. As MedPAC warns in its executive summary, "the risk that a formulaic expenditure target will fail and have unintended consequences is substantial."

Question for Dr. Thames:
You recommended in your testimony that Congress should take several steps to insulate Medicare beneficiaries from higher costs, specifically by capping the increase in Part B premiums and limiting total Part B out-of-pocket costs. Couldn't this have the adverse effect of Medicare beneficiaries wanting more medical care because they are protected from much of the cost?

Studies have shown that health care coverage can reduce sensitivity to the costs of care, but this is generally related to cost-sharing in the form of copayments and co-insurance, not premium increases, which are generally beyond the control of individual consumers.

As MedPAC's study points out, "cost-sharing should encourage beneficiaries to evaluate the need for discretionary care but should not discourage necessary care. . . . Medicare's FFS cost-sharing structure deviates substantially from this ideal. For example, Medicare imposes a relatively high deductible for hospital admissions, which are rarely optional."

AARP believes beneficiaries should continue to pay their fair share for Medicare services. We also believe the physician payment system needs to be reformed from one that rewards quality from one that rewards quantity. However, need to make sure beneficiaries are protected from extraordinary out-of-pocket expenses as the Part B payment system is reformed.

Senator Stabenow:

Questions for Dr. Thames:
MedPAC's Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System (March 1, 2007) does not make specific recommendations. Does Congress have the information we need to move forward with establishing a new payment system at this point? If not, what other information do we need?

AARP believes it's time for Medicare to move toward a system that elevates the value of care coordination, relies more heavily on information technology, and rewards physicians who provide effective, efficient, and patient-focused care, and those who make significant improvements in the quality of care they provide.

We don't believe we have all the information we need at this point, but we believe we must start to move in that direction right away. AARP supports the bonus incentive payments to physicians who report on quality measures that were included in physician payment update legislation for 2007. We believe these quality reporting efforts begin to move Medicare in the important direction of providing better quality and more value for beneficiaries. However, there is still substantial work to be done on the quality measures themselves so that when we actually pay-for-performance there will be rigor in the process to justify spending Medicare resources on this initiative.

AARP believes that the federal government must financially support the development of performance measures. Improving health care should be considered a public good and we will not be able to improve quality unless we have valid and reliable measures to assess what we are doing. Measures should be vetted through an open forum with meaningful consumer input (such as the National Quality Forum).

There are many gaps in our ability to assess health care quality. These gaps must be filled as quickly as possible. We need to improve risk adjustment methods to remove any incentives doctors may have to avoid patients with multiple chronic conditions, or inadvertently penalize providers in underserved communities.

How can we determine whether the volume of physician services currently being provided, and projected under different payment systems, is appropriate or inappropriate?

In its discussion of an outlier policy and measuring resources and providing feedback, MedPAC provides convincing arguments for why CMS should measure physicians' resource use over time and provide the results to physicians. AARP strongly recommends that CMS adopt this recommendation, especially if the SGR is eventually repealed. It is critically important that the Medicare program continue to focus efforts on ways to help physicians practice most appropriately. We would hope that the information could eventually be used to help beneficiaries identify those physicians who deliver high quality care. It could also eventually be used to help design payment policies.

We still do not know enough about which services are appropriate or inappropriate. One of the major advantages of the outlier approach is that it would allow the Medicare program and others to learn from those physicians who use fewer resources while maintaining a high level of quality. This information could be used to identify best practices for the treatment of specified patients and conditions.

Statement

of the

American Medical Association

Committee on Finance
United States Senate

RE: Medicare Payment for Physician Services: Examining New Approaches

Presented by: Cecil B. Wilson, MD

March 1, 2007

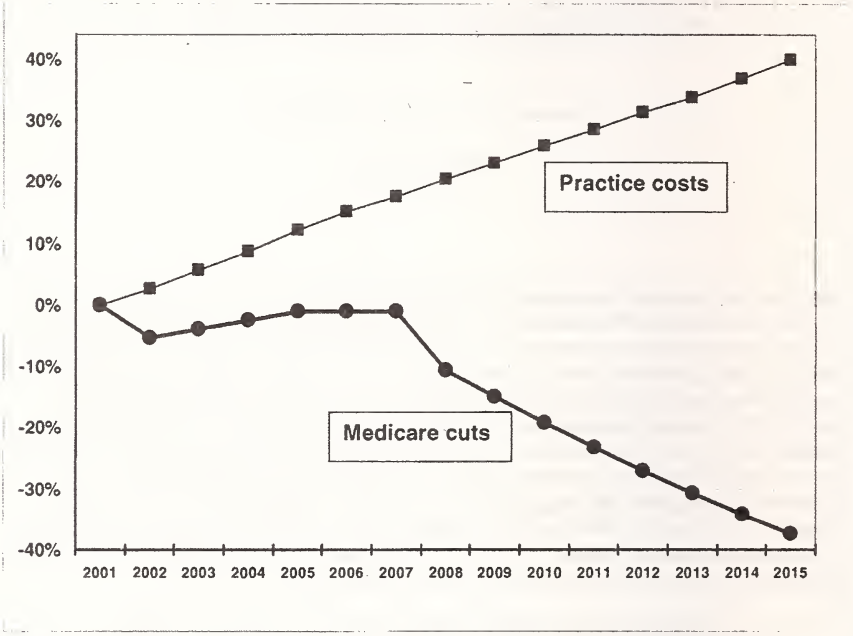
The American Medical Association (AMA) appreciates the opportunity to provide our views regarding the Medicare Payment Advisory Commission (MedPAC) Report to Congress on alternatives to the Medicare sustainable growth rate (SGR) physician payment formula. We commend you, Chairman Baucus, Senator Grassley, and Members of the Committee for all of your hard work and leadership in recognizing the fundamental need to address the fatally flawed SGR physician payment formula. It is time to find a replacement for this formula in order to ensure a firm foundation for the Medicare program both for the short- and long-term, especially as the program prepares to accept a huge influx of new enrollees as the baby boomers reach eligibility age, beginning in 2010. We are confident that working together, Congress, the Centers for Medicare and Medicaid Services (CMS), and organized medicine can achieve this goal and deliver on Medicare's long-held promise to patients — access to quality health care services furnished by the beneficiary's physician of choice.

PROJECTED PAYMENT RATES UNDER THE MEDICARE SUSTAINABLE GROWTH RATE PHYSICIAN PAYMENT FORMULA

The AMA is grateful to the Committee and Congress for taking action in each of the last five years to forestall steep Medicare physician payment cuts, due to the flawed SGR physician payment formula. We also appreciate that Congress, thanks to the efforts of the Chairman and Ranking Member of this Committee, has allocated to the Secretary of the Department of Health and Human Services under H.R. 6111, the "Tax Relief and Health Care Act of 2006," $1.35 billion to help offset the 2008 Medicare physician pay cut, and we look forward to working with CMS in the implementation of this provision. Despite these efforts, however, a Medicare meltdown still looms and it must be resolved. **Medicare payments to physicians in 2007 are essentially the same as they were in 2001, and a cut of 10% is projected for**

2008. Further, due to the SGR, physicians face drastic payment rate cuts totaling almost 40% over eight years (beginning in 2008), while physician practice costs will increase nearly 20% during that time period. These cuts come at a time when Medicare payments to physicians already lag far behind the cost of caring for seniors and just as the baby-boomers enter the Medicare program. (In 2010, the leading edge of the baby-boom generation will start enrolling in Medicare, with enrollment growing from 43 million in 2010 to 49 million by 2015.)

The chart below shows the gap in Medicare payment to physicians from 2001 through 2015, as compared to increases in medical practice costs, as measured by the government's own Medicare Economic Index (MEI).



Sources: Physician cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment updates are from the 2006 Medicare Trustees report, with adjustments for 2008 to reflect the Congressional Budget Office analysis of the "Tax Relief and Health Care Act of 2006." Any change in pay that may result from use of the $1.35 billion "physician assistance and quality initiative fund" for 2008 is not included.

Physicians cannot absorb these draconian Medicare cuts. A 2006 AMA survey showed that that patient access will suffer as a result of the cuts. Further, a national poll conducted by the AMA shows that 82% of current Medicare patients are concerned about the cuts' impact on their access to health care. A staggering 93% of baby boomers age 45-54 are concerned about the cuts' impact on access to care.

In the long-run, all patients will have more trouble finding a physician. The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020. Multi-year cuts in Medicare are nearly certain to exacerbate this shortage by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older.

Accordingly, we urge the Committee and Congress to work with CMS to avert future cuts by repealing the SGR and enacting a system that produces positive physician payment updates that accurately reflect increases in medical practice costs, as indicated by the MEI.

MEDICARE PAYMENT ADVISORY COMMISSION REPORT TO CONGRESS ON ALTERNATIVES TO THE SUSTAINABLE GROWTH RATE

The Deficit Reduction Act of 2005 (DRA) directed MedPAC to report to Congress, by no later than March 1, 2007, on mechanisms that could be used to replace the SGR. In large part, MedPAC's report is required to focus on methods for assessing and addressing volume growth in Medicare physicians' services while maintaining access to these services, as well as exploring whether an SGR-like target could be applied to a group practice, hospital medical staff, type of service, geographic area, as well as to outliers. In accordance with this Congressional mandate, MedPAC has issued its report to Congress, with several recommendations, as discussed below.

MedPAC Recommends A Positive Medicare Physician Payment Update For 2008 Equal To The Medicare Economic Index

In a separate March 2007 Report to Congress, MedPAC is expected to recommend that Congress establish a 1.7% Medicare physician payment update for 2008, which is intended to reflect a conservative rate of medical practice cost inflation, as measured by the MEI. **The AMA strongly supports this recommendation, and urges the Committee and Congress to avert next year's projected 10% cut and replace it with a positive 1.7% payment update, as recommended by MedPAC.** This is critical since physician payment updates have not kept up with practice cost increases for the last six years.

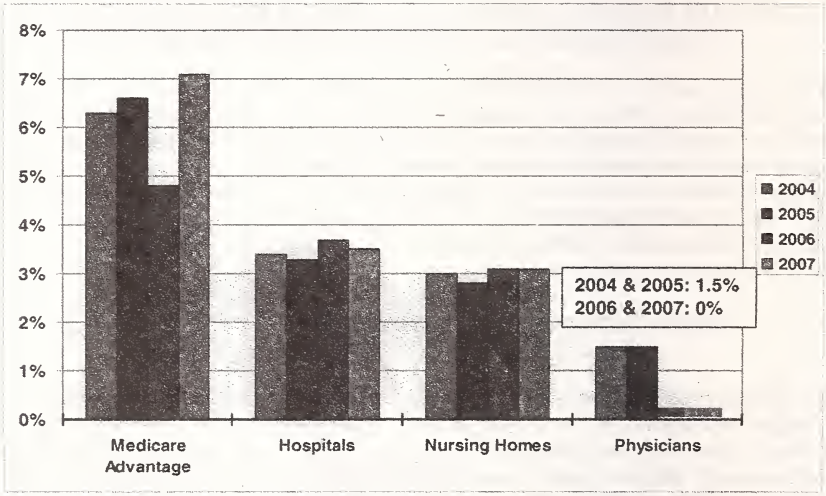
MedPAC's First Solution For The SGR: Repeal The Flawed SGR Formula

In considering a long-term approach to modernizing how Medicare pays physicians, MedPAC lays out two alternative "pathways" for Congress to consider. Under the first alternative, MedPAC reiterates its past recommendation that Congress repeal the SGR, while accelerating Medicare adoption of techniques used by private payers to control costs.

Repealing the SGR is consistent with MedPAC's long-held view that the SGR is a flawed formula for setting Medicare physician payment rates because it does not provide appropriate incentives for addressing volume growth that may be inappropriate. **Given the fatal flaws in the SGR formula and the resulting cuts that threaten the foundation of the Medicare program, the AMA strongly supports its repeal.** We believe that the SGR should be

abandoned altogether and replaced with a system that adequately reflects increases in physicians' medical practice costs. Only physicians and other health professionals (whose payment rates are tied to the physician fee schedule) face steep payment cuts. The chart below shows that physicians received below-inflation updates in 2004 and 2005, and freezes in 2006 and 2007, while other Medicare providers' payment updates have kept pace with their costs increases. Physicians and other health care professionals must have payment updates that keep pace with their cost increases, similar to the updates for other providers. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services to maintain stable access for our nation's seniors.

Physicians vs. other providers: 2004-2007 Medicare payment updates



Source: Centers for Medicare & Medicaid Services final announcements.

Techniques To Assure Appropriate Use Of Medical Care
Are More Effective Than Spending Targets

MedPAC believes that repeal of the SGR should be predicated on adoption of mechanisms that would be put in place to address appropriate use of physicians' services. It is understandable that policymakers want some assurances that spending on these services will not increase inappropriately. The AMA believes that targeted efforts by medical professionals themselves to identify and correct inappropriate use of services would be far more effective than a spending target in constraining system-wide health care costs. We are prepared to work with Congress, the Administration, and MedPAC to explore alternatives designed to distinguish between appropriate and inappropriate services and foster prudent utilization behavior by physicians and patients. To that end, the AMA has been working with

numerous organizations representing physicians and other health professionals to identify mechanisms that would bridge current gaps in care and assure appropriate use of medical care. With these organizations, we have developed the attached document entitled "Joint Recommendations to Congress on Eliminating the SGR and Supporting Efforts to Promote Health Care Quality and Appropriateness."

These "Joint Recommendations" focus on repealing the SGR and replacing it with a system that reflects continual increases in physicians' and other health professionals' practice costs, as the first priority. Along with repeal, we jointly call on Congress to support initiatives by the profession to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries. Such support, as stated in the "Joint Recommendations," could include —

- Instructing HHS to work with organizations of physicians and other professionals to develop methodologies to provide accurate, confidential and comparative information to individual practitioners on how their quality and utilization compares to their peers as tools for self-improvement.
- Encouraging efforts by organizations representing physicians and other health professionals to develop voluntary guidelines on the appropriate utilization of services and to obtain and analyze data on the growth in the utilization of services and quality of services by condition, type of service, episodes of illness, region and specialty.
- Providing financial support and positive incentives to help and encourage acquisition of the tools and information technology needed to provide consistent and high quality care.
- Directing Medicare to pay medical practices for care coordination services that fall outside of a face-to-face encounter. System-wide savings—such as reductions in hospital admissions and readmissions (Part A) and more effective use of pharmacologic therapies (Part D)—achieved by these programs should be applied to funding the care coordination services. If enacted by Congress, such a policy should be considered a change in law that would not require a budget neutrality offset in the Medicare Physician Fee Schedule.
- Supporting efforts by the profession, the RUC [the AMA/Specialty Society RVS Update Committee], and CMS to improve the accuracy of Medicare's resource-based relative value scale to ensure that all costs, including uncompensated care and updated practice expenses, are recognized and that the payment system does not inadvertently encourage inappropriate treatment decisions.

The key ingredient for success in efforts to identify and prevent any inappropriate use of physicians' services is committed physicians. This is only possible under a system that seeks physician input early in the process and that is built from the ground up rather than one that imposes arbitrary targets set by federal officials and based on imperfect data.

Physicians have a solid track record for working together in addressing policymakers concerns. For example, the AMA convened the Physicians' Consortium for Performance Improvement in 2000 for the development of performance measurements. The Consortium is currently comprised of over 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies; American Board of Medical Specialties and its

member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and CMS. The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are also liaison members.

Through the Consortium, physicians have had exceptional success in developing physician-level performance measures and it has become the leading physician-sponsored initiative in the country. To date, the Consortium has developed 155 performance measures and 60 of the 74 measures in Medicare's Physician Quality Reporting Initiative (PQRI), came from the Consortium. The PQRI is the Medicare physician reporting program being implemented by CMS, and it will be used as the basis for physician reporting in 2007 under the reporting program established by H.R. 6111. We wish to underscore, however, that the attached "Joint Recommendations" include a call for the transitional 2007 PQRI to be re-examined before being expanded into future years to ensure, for example, that the program focuses on meaningful improvements in patient care.

The AMA emphasizes to the Committee our strong commitment to continuing the foregoing quality initiatives. We also offer our firm commitment to working with Congress, CMS, and MedPAC to develop techniques to assure the appropriateness of services, while repealing the SGR and ensuring a stable Medicare program that delivers to our seniors and disabled patients high quality, cost-effective health care services.

MedPAC's Second Alternative Solution: Expand The SGR Spending Target

Under the second alternative "pathway" for solving the SGR crisis, MedPAC outlines a plan that would move to regional spending targets that apply to all Medicare services and providers. This would be implemented on a phased-in basis, and hospital outpatient departments would be the first provider to which the target would be expanded. Newly-created organizations of hospitals and physicians called "accountable care organizations" could then receive payment bonuses if their spending growth is below the regional target.

The AMA emphasizes that MedPAC's second alternative is presented on a conceptual basis only. MedPAC has not had an opportunity to thoroughly discuss or work out the details for implementation of this type of system, and as discussed below, such implementation would run into significant obstacles. In fact, MedPAC has previously discussed expanding the SGR spending target to ambulatory care facilities, and recommended against this approach in its March 2000 report.

MedPAC essentially concluded that an expanded target was unworkable because there is no way to predict and adequately adjust for shifts in site-of service with a rigid formula, such as the SGR. MedPAC also simulated the impact of including hospital outpatient and ambulatory surgical services (ASC) in the SGR and concluded that this would "reduce the updates for all services in the expanded system" by 1% to 3%. Since hospital outpatient department spending is now higher than what MedPAC simulated in 2000, the impact of this change is likely to be larger today. **The AMA concurs with this discussion from 2000, and we continue to strongly oppose expansion of the SGR or any spending target.** The AMA, however, does not disagree with MedPAC's long-term vision of hospitals and physicians working together in accountable care organizations. The details of this approach are

important. In our view, a mechanism that establishes positive incentives that foster voluntary alliances will have a far greater chance of success than using "top-down" spending targets to drive the development of these kinds of alliances.

Spending Targets And The SGR Undermine The Use Of Health Information Technology And Quality Initiatives

Spending targets are also problematic in that they undermine policymakers' vision of a Medicare health care system that uses health information technology (HIT) and quality initiatives to deliver the highest quality of care to Medicare patients. In fact, spending targets are in direct conflict with this vision because quality initiatives often encourage greater utilization of physicians services through the use of more preventive and chronic disease management services. Yet, the SGR (or other similar spending target) penalizes volume increases that exceed the target through additional payment cuts. Further, these payment cuts destabilize the foundation of the Medicare program and make it nearly impossible for physician practices, which for the most part operate as small businesses, to make the substantial financial investment required for HIT and participation in quality improvement programs. Indeed, a study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider.

Without positive payment updates, it will be difficult for physicians to make these HIT investments. In fact, a 2006 AMA survey showed that if Medicare physician cuts take effect through 2015, as projected by the Medicare Trustees, 73% of responding physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology. Thus, to fulfill policymakers' vision, Medicare payments to physicians must be premised on a stable physician payment system that provides positive payment increases to physicians and accurately reflects increases in physicians' practice costs.

Spending Targets Do Not Achieve Their Goals

Spending targets, such as the SGR inevitably miss the mark because the target is based on a flawed formula that inaccurately estimates Medicare beneficiaries need for physicians' services versus actual consumption of services, and penalizes physicians with pay cuts when they provide needed services that exceed the spending target. Therefore, Congress should not replace one target for another, but should scrap the entire idea of a target, which is fundamentally flawed.

Further, spending targets cannot achieve their goal of restraining volume growth by discouraging inappropriate care. Spending targets apply to a whole group and, therefore, do not provide an incentive at the individual physician level to control spending. In addition, they do not distinguish between appropriate and inappropriate growth because they apply across-the-board to all services. In addition, spending target systems are based on the fallacious premise that physicians alone can control the utilization of health care services, while ignoring patient demand, government policies, technological advances, epidemics, disasters, and the many other contributors to volume growth.

As discussed below, volume growth in physicians' services can be attributed to a number of factors, including government policies, and the AMA cautions the Committee that volume growth does not automatically equate to inappropriate growth. We urge the Committee to ensure that Medicare payment policies are not based on this flawed assumption.

Many Factors Outside Of Physicians' Control
Account For Growth In The Volume Of Health Care Services

A key factor that contributes to the volume growth is that more and more elderly suffer from serious and costly chronic conditions, such as obesity, diabetes, kidney failure, and heart disease. In recent testimony before Congress, Bruce Steinwald, Director of Health Care for the Government Accountability Office (GAO), stated that obesity, smoking, and other population risk factors lead to expensive chronic conditions (including diabetes and heart disease) which drive growth in the utilization of health care resources and spending. Director Steinwald cited research by Kenneth Thorpe attributing 27% of the growth in inflation-adjusted per capita spending between 1987 and 2001 to the rising prevalence of obesity and higher relative per capita spending among obese individuals.

In addition, we are treating diseases earlier, and, as a result of chronic disease intervention and evolutionary changes in the practice of medicine, we have more elderly and disabled Americans living longer, active lives. For example, advances in medical imaging techniques have made it possible to detect cancer at earlier, more treatable stages, target and reduce the side-effects of therapeutic radiation, and pinpoint the impact and treatment of strokes and other conditions.

Another contributing factor to volume growth is that appropriate medical care often requires continued monitoring and sometimes repeated procedures for many patients. For example, an implanted cardiac defibrillator requires two check-up visits a year for the rest of the patient's life.

Moreover, technological advances and changes in Medicare payment policies have facilitated a shift in care from the more expensive hospital setting (*i.e.*, Part A) to physicians' offices (*i.e.*, Part B), which has contributed to increased growth in physicians' offices. Specifically, the National Centers for Vital and Health Statistics (NCVHS) show that hospital days per 1000 population between 1995 and 2002 declined by more than 15% among 65 to 74 year olds and by more than 10% for those 75 and older. Over that same period, as physicians filled the gaps in care created by earlier hospital discharges and increasingly treated patients outside the hospital, seniors' office visits rose by 24%. Quality improvement initiatives that focus on gaps in care have also reached out to more beneficiaries, which, in turn, has increased volume in physicians' offices. This trend may continue as the Medicare physicians reporting program, enacted under H.R. 6111, the "Tax Relief and Health Care Act of 2006," is implemented on July 1 of this year. Quality initiatives have led to fewer hospital admissions, shorter lengths of stay, longer life spans with better quality of life, and fewer restrictions in activities of daily living among the elderly and disabled.

Finally, government policies substantially contribute to increased services in physicians offices, especially those that promote new Medicare benefits for preventive care services (such as Medicare coverage of an initial preventive physical examination for new Medicare enrollees). These policies also include national coverage decisions (NCDs) by which CMS announces changes and expansions in Medicare benefits, which increases spending on physicians' services. Although CMS issued over 100 NCDs between 1999 and 2006, the agency has not reflected the full impact on physician spending due to such expansions in Medicare benefits when setting the SGR spending target for physician's services. In testifying before Congress this last month, Bruce Steinwald, of the GAO, stated that "[w]hat we do in this country, basically, through our approval processes and our coverage processes in both public and private sector is rather than control the spigot and control the flow of technologies at the spigot, we basically turn the spigot on full force and then stick our thumb in the bottom to see if we can gain control, and that's not a very efficient way of doing it."

The foregoing discussion suggests that while a number of factors drive appropriate volume growth, this spending on physicians' services is a good investment. For example, over the last decade, life expectancy has risen for both women and men, and 65-year-olds of both sexes can now expect to become octogenarians. Further, mortality rates in this century have been falling by about 3% a year for certain prevalent diseases such as heart, stroke, and other cerebrovascular disease, while deaths from cancer have declined by about 1% a year over the last decade. Specifically, the National Center for Health Statistics recently reported that there were 50,000 fewer U.S. deaths in 2004, the biggest single-year drop in mortality since the 1930s. Not only are beneficiaries living longer, they are living better. Thousands of stroke, hip fracture, emphysema, and heart failure patients who once would have faced a bed-ridden future now are rehabilitated and return home to relatively independent lives.

We urge Congress, in developing a new physician payment system, to ensure that the first priority is to meet the health care needs of our elderly and disabled patients. To achieve this goal, Congress and policymakers should not impose spending targets that penalize all physicians through a formula tied to volume growth. **Where inappropriate volume growth is identified in a particular type of medical service, Congress, CMS, and organized medicine should address it through development of the mechanisms described in the "Joint Recommendations" referenced above. This would allow Congress and CMS to deal with the source of the increase, thereby ensuring more control over the process than exists under the current system.**

MedPAC's Identification Of Possible Modifications To The SGR

In addition to recommending alternative solutions to the SGR, MedPAC has identified methods for modifying the SGR formula to make it somewhat less onerous. MedPAC has identified certain options, including:

- Eliminating the cumulative feature of the SGR and instead using annual targets so that multiyear deficits in target spending will not accrue and lead to multiyear pay cuts;
- Increasing the SGR target for utilization growth per beneficiary to GDP + 1 rather than GDP alone; and

- Setting a corridor that limits physician payment updates to within 2% of the MEI instead of the current limits of MEI plus three and minus seven.

The AMA continues to believe that repeal, not modification, of the SGR is the best solution. Each of the foregoing options would leave in place a flawed payment formula and would not likely lead to positive physician payment updates in the future. Combining all of the options would make positive future updates more likely than under the current formula. Yet, the cost of enacting these combined modifications is likely to be nearly as much as repealing the SGR and replacing it with MEI updates.

Application Of The SGR To Smaller Units

As directed by Congress, MedPAC also examined the pros and cons of various "mini SGRs," which would apply an SGR-like target based on specialty, service category, geographic region, medical groups, hospital medical staffs, and outlier physicians. Again, the AMA urges repeal of the SGR, and we do not support adoption of mini-SGRs, which we believe would be just as problematic as the current SGR system. "Mini-SGRs" would still impose an arbitrary and inaccurate spending target that relies on unpredictable assumptions that often bear very little relationship to the health care needs of our Medicare patients. More importantly, unless these "mini-SGRs" begin in a "deep hole" with negative updates, these alternatives would be very costly.

An analysis by AMA economists suggests that reversing the current projected cuts, due to the SGR, would require a combination of options with costs that are close to price tag that the Congressional Budget Office has calculated for MedPAC's original proposal to repeal the SGR and replace it with MEI updates. This price tag is significant, but without a substantial infusion of funds, the SGR, with its inevitable steep cuts, will continue to dictate enactment of short-term fixes that only increase the cost of long-term solutions. We remind the Committee that CMS can help significantly reduce the cost of repealing the SGR through immediate administrative actions, as discussed below.

ADMINISTRATIVE ACTIONS TO REDUCE THE COST OF REPEALING THE SGR

We urge the Committee to press CMS to assist Congress in repealing the flawed SGR formula through immediate administrative actions that would significantly reduce the cost of such repeal.

CMS Should Remove Drug Costs Retroactively From The Calculation Of The SGR

When CMS identifies Medicare spending on "physicians' services" for purposes of calculating the SGR, it includes the cost of Part B physician-administered drugs. Yet, CMS has the discretion to exclude the drugs from this definition of "physicians' services." Further, CMS has the legal authority to remove these physician-administered drugs from the SGR retroactive to 1996, thus far the agency has declined to do so despite requests from this Committee, as well as other Congressional leaders and organized medicine. In July 2005, 89

Senators and virtually all Members of the Committee signed a letter to the Office of Management and Budget (OMB) Director urging the Administration to remove the cost of these drugs from the SGR calculations.

It is also inequitable to include drug expenditures in calculations of the SGR because drugs continue to grow at a very rapid pace. For example, spending for only one recently-developed drug, Pegrilgrastim (Neulastra) totaled $518 million in 2004, thus accounting for a significant proportion of Medicare spending growth under the SGR. Further, drug expenditure growth has far outpaced that of the physician services that the SGR was intended to include, and Medicare actuaries predict that drug spending growth will continue to significantly outpace spending on physicians' services for years to come. This lopsided growth lowers the SGR target for actual physicians' services and significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target. In 1996, drug spending was less than 4% of SGR spending. By 2005, it had grown to 9% and by 2017 it could be nearly 20%. **While the AMA supports the significant benefits that these drugs provide to patients, it is not equitable or realistic to include the cost of these drugs in the SGR, and CMS should remove them retroactively to 1996.**

Medicare Physician Spending Due To
National Coverage Decisions (NCDs) Should Be Reflected In The SGR

When establishing the SGR spending target for physicians' services, CMS, by statute, is required to take into account the impact on physician spending due to changes in laws and regulations. Changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as Program Memorandums or national coverage decisions (NCDs) which implement coverage change and expansions, constitute a regulatory change. Yet, CMS does not reflect the impact on physician spending due to NCDs when calculating the SGR target. As discussed above, CMS has issued over 100 NCDs from 1999 through 2006.

When the impact of NCD expansions on physician spending is not taken into account for purposes of the SGR, this causes aggregate physician spending to exceed the SGR target at even greater rates. For example, CMS has used the NCD process to either: (i) reverse a previous decision not to cover; or (ii) to expand current Medicare coverage for positron emission tomography (PET scans), bariatric surgery for treatment of obesity, transluminal percutaneous angioplasty with carotid artery stents, and ocular photodynamic therapy with Verteporfin for patients with macular degeneration. These NCDs add considerably to spending under the SGR but, by not counting such benefit expansions as changes in law and regulation for purposes of calculating the SGR, they increase the likelihood of SGR-driven pay cuts.

Physicians are then forced to finance the cost of these program changes and expansions through cuts in their payments. Not only is this supposed to be precluded by the SGR law, it is extremely inequitable and ultimately could adversely impact beneficiary access to important services. CMS has stated its view that it would be very difficult to estimate any costs or savings associated with specific coverage decisions and that any adjustments would likely be small in magnitude and have little effect on future updates. **Yet, CMS already adjusts Medicare Advantage payments to account for NCDs, so it clearly is able to**

estimate their costs. Thus, CMS should include the impact on physician spending due to these NCDs for purposes of calculating the SGR.

MEDICARE BENEFICIARY PREMIUMS

As we work to repeal the SGR, CMS and policymakers have noted that an increase in Medicare payments for physicians and other health professionals would, in turn, increase the Medicare Part B premium for beneficiaries. Physician pay cuts, however, will ultimately cost beneficiaries more because these cuts will force physicians to discontinue providing certain services in the physician's office or force longer wait times for a physician office visit. Rather, patients will have to receive these services in higher-cost hospital or emergency department settings. This means that Medicare patients will experience more inconvenience and higher deductibles and co-payments when they are treated in the hospital.

Further, increased spending on other services, such as hospital outpatient services also increases beneficiary premiums, yet, as discussed above, other providers continue to receive payment updates that keep pace with their medical inflation. In announcing Medicare premiums for 2007, CMS stated that "very rapid growth in hospital outpatient services is a major contributor to the premium increase. Although outpatient hospital spending accounts for only about 13 percent of total Part B spending, it accounts for one-third of the increase in the 2007 premium." In fact, spending for physician fee schedule services accounted for only about 14% of the increase in the Medicare premium for 2007. Accordingly, updates to all providers contribute to premium increases, and the AMA asks to have parity with these other providers.

Finally, we note that according to CMS, about one in four Medicare beneficiaries are protected from premium increases because they can get extra assistance that enables them to pay little to no premium for Medicare Part B services.

The AMA appreciates the opportunity to provide our views to the Committee on MedPAC's report and other critical matters. We look forward to working with the Committee and Congress to repeal the SGR and avert its resulting cuts, initiate mechanisms to assure appropriate use of physicians' services, and preserve patient access to high quality, cost-effective care.

Joint Recommendations to Congress
On Eliminating the SGR
And
Supporting Efforts to Promote Health Care Quality and Appropriateness

1. The SGR should be repealed and replaced with an update system that reflects increases in physicians' and other health professionals' practice costs.
   - All of the targets that Congress has said should be examined as a possible alternative to the SGR will have a significant cost.
   - All of the alternatives currently under consideration—including regional targets and expanding the targets to include hospitals, nursing homes and other providers—would inject significant administrative and political complexities.
   - These alternatives also could create obstacles to the purchase of health information technology for quality improvement and to the development of care coordination programs.

2. Congress should support initiatives by organizations representing physicians and other health care professionals to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries. Such support could include:
   - Instructing HHS to work with organizations of physicians and other professionals to develop methodologies to provide accurate, confidential and comparative information to individual practitioners on how their quality and utilization compares to their peers as tools for self-improvement.
   - Encouraging efforts by organizations representing physicians and other health professionals to develop voluntary guidelines on the appropriate utilization of services and to obtain and analyze data on the growth in the utilization of services and quality of services by condition, type of service, episodes of illness, region and specialty.
   - Providing financial support and positive incentives to help and encourage acquisition of the tools and information technology needed to provide consistent and high quality care.
   - Directing Medicare to pay medical practices for care coordination services that fall outside of a face-to-face encounter. System-wide savings—such as reductions in hospital admissions and readmissions (Part A) and more effective use of pharmacologic therapies (Part D)—achieved by these programs should be applied to funding the care coordination services. If enacted by Congress, such a policy should be considered a change in law that would not require a budget neutrality offset in the Medicare Physician Fee Schedule.
   - Supporting efforts by the profession, the RUC, and CMS to improve the accuracy of Medicare's resource-based relative value scale to ensure that all costs, including uncompensated care and updated practice expenses, are recognized and that the payment system does not inadvertently encourage inappropriate treatment decisions.

3. If immediate repeal of the SGR is not possible, Congress must:
   - Establish by law a transition, pathway and "date certain" to complete elimination of the SGR.
   - Provide positive physician/health care professional updates set by statute for each year until repeal takes effect.
   - Stabilize payments for a minimum of two years by providing positive baseline updates to all physicians/health care professionals.

- Consistent with the Medicare Payment Advisory Commission's recommendation, a scheduled cut of 10% in 2008 should be replaced with an increase of 1.7% and CMS should be urged to use the $1.35 billion fund provided in H.R. 6111 to help stabilize the update
- In 2009, the update should similarly reflect increases in the costs of providing services instead of an anticipated cut of 5% or more.

- Spend down the costs of repealing the SGR by fully funding the positive updates.
- Urge the Administration to exercise its authority to remove physician-administered drugs from the SGR and make other refinements in the formula to help reduce the cost of Congressional action.

4. The transitional 2007 Medicare Physicians Quality Reporting Initiative should be re-examined before being expanded into future years.
   - The program should focus on meaningful improvements in patient care rather than conditioning positive updates for all physicians and practitioners on "reporting for the sake of reporting."
   - It should be designed so that timelines for implementation are realistic and CMS has the capability to effectively administer the program.
   - If the program is continued beyond 2007, funding should be sufficient to provide additional payments beyond the positive inflation update for those who report on clinical measures.
   - Any physician-level clinical measures used in a pay-for-reporting program must be developed through a multi-specialty consensus process organized by medicine (the Physicians' Consortium for Performance Improvement).

5. To make Medicare sustainable in the future, Congress should identify and begin to enact additional reforms which will be necessary to create incentives for judicious use of services and to adequately fund the program.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD FROM DR. CECIL B. WILSON

UNITED STATES SENATE COMMITTEE ON FINANCE HEARING MEDICARE PAYMENT FOR PHYSICIAN SERVICES: EXAMINING NEW APPROACHES MARCH 1, 2007

Chairman Baucus:

Question: Why does the growth in physician spending vary so dramatically across geographical regions? What is the physician community doing to address the rapid growth in physician spending and variation across geographical regions?

There are many factors that account for growth in the utilization of physicians' services and variations in physician spending across geographic regions. In announcing the 2007 Part B premium, the Administration noted that "the growth rate in 2005 spending for physician fee schedule services slowed compared to trends in recent years" and that hospital outpatient department spending is growing much more rapidly than spending on physicians' services. Government policies that encourage rapid development and adoption of new drugs to treat cancer, as well as expansions in Medicare coverage, also contribute to utilization growth.

Factors that may contribute to geographic variation in spending include demographic, socioeconomic, environmental and cultural factors that are endemic to particular regions, such as rates of compliance with prescribed therapies, as well as rates of smoking and obesity. Although studies that have looked at variation in utilization of services attempt to adjust for these differences, current adjusters do not take many of the key contributors to medical utilization fully into account.

The AMA, along with 76 organizations representing physicians and other health professionals, has developed a document entitled "Joint Recommendations to Congress on Eliminating the SGR and Supporting Efforts to Promote Health Care Quality and Appropriateness." Recommendations in this document would help address growth and geographic variation in physician spending.

Specifically, we have jointly recommended that, along with repeal of the sustainable growth rate (SGR) Medicare physician payment formula, Congress should support initiatives by the profession to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries. Such initiatives, as stated in the "Joint Recommendations," could include —

- Instructing HHS to work with organizations of physicians and other professionals to develop methodologies to provide accurate, confidential and comparative information to individual practitioners on how their quality and utilization compares to their peers as tools for self-improvement.

- Encouraging efforts by organizations representing physicians and other health professionals to develop voluntary guidelines on the appropriate utilization of services and to obtain and analyze data on the growth in the utilization of services and quality of services by condition, type of service, episodes of illness, region and specialty.

The AMA is committed to working with the Committee and Congress to further develop these recommended initiatives which would provide the medical profession with the necessary data to analyze growth in utilization by region, specialty, and other factors. This, in turn, would help to influence physician behavior if inappropriate care is identified.

Question: Wouldn't it be best to implement reforms from "the ground up" to change the incentives of the payment system, rather than impose a "top down" target on spending?

The AMA believes that it is best to encourage judicious use of medical care from "the ground up," rather than impose a "top-down" target on spending. Spending targets undermine the types of health system and Medicare physician payment reforms envisioned by Congress and other policymakers. Specifically, spending targets conflict with development of a Medicare health care system that uses health information technology (HIT) and quality initiatives to deliver the highest quality of care to Medicare patients. In fact, quality initiatives often encourage greater utilization of physicians services through the use of more preventive and chronic disease management services. Yet, the SGR and other spending targets penalize physicians for volume increases (even if appropriate) that exceed the target through additional payment cuts. These cuts destabilize the foundation of the Medicare program and make it nearly impossible for physician practices, which for the most part operate as small businesses, to make the substantial financial investment required for HIT and participation in quality improvement programs. In fact, a 2006 AMA survey showed that if Medicare physician cuts take effect through 2015, as projected by the Medicare Trustees, 73% of responding physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology.

Further, spending targets cannot achieve their goal of restraining volume growth by discouraging inappropriate care. Spending targets do not distinguish between appropriate and inappropriate growth because they apply across-the-board to all services. Moreover, spending targets apply to all physicians (as a whole group) and, therefore, do not provide an incentive at the individual physician level to restrain spending. Volume growth in physicians' services results from a number of factors, including the increased prevalence of costly chronic conditions, government benefit expansions, new life-saving technologies, shifts in care from the more expensive hospital setting to physicians' offices, and an aging population.

The AMA urges the Committee, in developing a new physician payment system, to ensure that the first priority is to meet the health care needs of our elderly and disabled patients. To achieve this goal, Congress and policymakers should not impose "top down"

spending targets that penalize all physicians through a flawed formula tied to volume growth. Where inappropriate volume growth is identified in a particular type of medical service, Congress, the Centers for Medicare and Medicaid Services (CMS), and organized medicine should address it through a "ground up" approach that involves the entire medical community.

To that end, as discussed above, the AMA, along with 76 organizations representing physicians and other health professionals has developed "Joint Recommendations" for identifying mechanisms that would bridge current gaps in care and assure appropriate use of medical care. These mechanisms include —

- Instructing HHS to work with organizations of physicians and other professionals to develop methodologies to provide accurate, confidential and comparative information to individual practitioners on how their quality and utilization compares to their peers as tools for self-improvement.
- Encouraging efforts by organizations representing physicians and other health professionals to develop voluntary guidelines on the appropriate utilization of services and to obtain and analyze data on the growth in the utilization of services and quality of services by condition, type of service, episodes of illness, region and specialty.
- Providing financial support and positive incentives to help and encourage acquisition of the tools and information technology needed to provide consistent and high quality care.
- Directing Medicare to pay medical practices for care coordination services that fall outside of a face-to-face encounter. System-wide savings—such as reductions in hospital admissions and readmissions (Part A) and more effective use of pharmacologic therapies (Part D)—achieved by these programs should be applied to funding the care coordination services. If enacted by Congress, such a policy should be considered a change in law that would not require a budget neutrality offset in the Medicare Physician Fee Schedule.
- Supporting efforts by the profession, the RUC [the AMA/Specialty Society RVS Update Committee], and CMS to improve the accuracy of Medicare's resource-based relative value scale to ensure that all costs, including uncompensated care and updated practice expenses, are recognized and that the payment system does not inadvertently encourage inappropriate treatment decisions.

The AMA is firmly committed to working with Congress, CMS, and the Medicare Payment Advisory Commission (MedPAC) to develop these mechanisms for assuring the appropriateness of services, while repealing the SGR and ensuring a stable "ground up" Medicare program that delivers to our seniors and disabled patients high quality, cost-effective health care services.

Question: Which of the "value-improving" options presented by MedPAC are ready to be implemented this year? Which will be most effective in incentivizing more efficient, higher quality care?

MedPAC discussed in its March 2007 Report to Congress a number of "value-improving" options for providing high-quality, low-cost care. These options, however, are in their initial stages of development, and while some are promising, it is unlikely that they would be ready for effective implementation this year. Even Medicare's Physician Quality Reporting Initiative (PQRI), enacted under H.R. 6111, the "Tax Relief and Health Care Act of 2006," has complex issues that must be resolved as we move toward implementation of this physician reporting program. In fact, the above-referenced "Joint Recommendations" call for considering a more narrow focus on areas where there are documented gaps in patient care, rather than a broad expansion of the 2007 PQRI into future years.

This does not mean that progress on options that might encourage value-based care is not possible this year. In fact, Congress has already called for demonstrations that reward physicians for quality reporting and care coordination programs. The "Joint Recommendations" described above provide support for care coordination demonstrations, but call for Congress to provide new money for these services. As noted in the "Joint Recommendations," we believe that quality measures should be developed by physicians and agree with MedPAC that the current quality initiative should be redirected to focus on a more limited set of conditions where the correction of current gaps in care could make a significant improvement in patient care and has the potential to reduce hospital care associated with these conditions.

MedPAC also is continuing to examine the concept using "episode grouper" software to profile physicians' use of services to treat a particular episode of care. These profiles then could be used to compare an individual physicians' treatment patterns with those of his or her peers, which, in turn, would influence behavior if needed. Both MedPAC and CMS are conducting evaluations of these software programs. Although an undertaking of this magnitude and complexity will need serious analysis, as well as physician input, we believe that with proper implementation, this tool holds some promise. In the meantime, however, as the development and refinement process continues, at least initially, the data generated from these profiles should be provided to individual physicians on a confidential basis so that they can compare themselves with other physicians and make any warranted changes in their practice patterns.

We look forward to working with the Committee and Congress this year to develop these initiatives and enact any legislation that is needed to begin to collect and analyze data that will help the medical profession better analyze practice patterns and identify current gaps in care for assuring appropriate use of medical services.

Question: What is the physician community doing to encourage doctors to work in rural areas?

Improving health care access in rural and medically underserved areas is a priority for the AMA. In that regard, we greatly appreciate the leadership efforts of the Chairman and Ranking Member of the Senate Finance Committee in establishing a floor for the work geographic practice cost index (GPCI) for 2004 through 2007. Extension of the floor

helped to avert additional pay cuts in 53 physician payment areas, including numerous rural areas, and we look forward to working with the Committee and Congress to extend this floor for future years.

The AMA urges Congress to repeal the SGR and provide a stable Medicare physician payment system that ensures that payment rates for all physicians reflect increases in medical practice costs. Adequate payment rates allow physicians in rural areas, as well as those who maintain satellite offices in rural areas, to keep their doors open. It is difficult enough to maintain a medical practice in a rural area, especially with payment rates in 2007 about the same as they were in 2001. The projected 10% cut in Medicare physician payment rates for 2008, however, will be devastating for rural areas. According to a 2006 AMA survey, in rural areas, more than half of physicians (55%) said they will have to discontinue rural outreach services if the cuts projected by the Medicare Trustees are enacted through 2015.

The AMA also is working to help Congress enact other legislative initiatives to incentivize physicians to practice in rural areas. For example, in the 109th Congress we supported S. 2789, the "Rural Physicians Relief Act of 2006," which would have used tax incentives to encourage primary care physicians who currently practice in underserved rural areas to remain in such areas. It also would have provided an incentive to other physicians to locate their practices in rural areas. Longstanding AMA policy encourages Congress and state legislatures to develop incentives to make practice in underserved areas more attractive to primary care physicians in order to improve access to necessary medical services in these areas.

In addition, the AMA supports S. 588, the "Resident Shortage Reduction Act of 2007." This bill would expand the number of Medicare-supported physician residency training positions in states with a shortage of residents.

Moreover, the AMA has actively advocated that Congress restore full funding to the Health Professions Programs under Title VII of the Public Health Service Act, as well as the National Health Service Corps (NHSC). Title VII loans, loan guarantees, and scholarships to students, as well as grants and contracts to academic institutions and non-profit organizations, are an essential component of the nation's health care safety net. One half of primary care providers trained through Title VII programs go on to work in underserved areas, compared to just 10% of those trained in other programs. These programs have also proven to increase the diversity of the workforce, graduating up to five times more minority and disadvantaged students than programs that do not receive such support. Further, the NHSC is similarly vital to the health care of our nation. The NHSC works to make medical care accessible to the approximately 50 million people who live in communities without access to primary health care. NHSC helps recruit and retain primary care physicians and other health professionals.

Finally, the AMA, along with the National Association of Rural Health Clinics (NARHC), is continuing to work with the CMS concerning pending regulations affecting rural health clinics (RHCs). In fact, along with the NARHC and the Medical Group

Management Association, the AMA submitted written comments to CMS aimed at improving current RHC regulations to: (i) ensure that RHCs can continue providing essential health care services to rural communities; and (ii) make them a more attractive option for physicians.

The AMA looks forward to working with the Committee, Congress, and CMS in advancing these legislative and regulatory initiatives to ensure that appropriate incentives are in place to encourage physicians to practice in rural areas.

Senator Bunning:

Question: The second pathway suggested by MedPAC would replace the current physician formula with a new formula of expenditure targets and expand it to all providers under fee-for-service, among other things. The current physician formula hasn't worked well. What are the risks – or benefits – in using the same type of reimbursement system for all providers?

The AMA urges Congress to repeal the SGR spending target and replace it with a system that adequately reflects increases in the cost of practicing medicine. We do not support expansion of a spending target to all providers, as outlined under MedPAC's second pathway. The SGR does not work now. How can it be expected to work when applied to more providers? No amount of tinkering can fix what is broken beyond repair. In fact, MedPAC has previously discussed expanding the SGR spending target to ambulatory care facilities, and recommended against this approach in its March 2000 report. MedPAC essentially concluded that an expanded target is unworkable because there is no way to predict and adequately adjust for shifts in site-of service with a rigid formula, such as the SGR.

Spending targets are problematic for many reasons. They do not distinguish between appropriate and inappropriate growth because they apply across-the-board to all services. In addition, spending targets apply across all physicians (as a whole group), and, therefore, do not provide an incentive at the individual physician level to control spending. As such, they cannot succeed in discouraging inappropriate care or constraining utilization growth.

Applying the SGR spending target to physicians is particularly problematic because it undermines policymakers' vision of a Medicare health care system that uses HIT and quality initiatives to deliver the highest quality of care to Medicare patients. Finally, spending targets ignore the fact that many factors outside of physicians' control drive the volume of services. For example, more and more elderly suffer from serious and costly chronic conditions, such as obesity, diabetes, kidney failure, and heart disease. In recent testimony before Congress, Bruce Steinwald, Director of Health Care for the Government Accountability Office (GAO), stated that obesity, smoking, and other population risk factors lead to expensive chronic conditions (including diabetes and heart disease) which drive growth in the utilization of health care resources and spending. Director Steinwald cited research by Kenneth Thorpe attributing 27% of the growth in inflation-adjusted per

capita spending between 1987 and 2001 to the rising prevalence of obesity and higher relative per capita spending among obese individuals.

In addition, government policies substantially contribute to increased volume in physicians' services, especially those that promote new Medicare benefits for preventive care services (such as Medicare coverage of an initial preventive physical examination for new Medicare enrollees). In testifying before Congress this last month, Bruce Steinwald, of the GAO, stated that "[w]hat we do in this country, basically, through our approval processes and our coverage processes in both public and private sector is rather than control the spigot and control the flow of technologies at the spigot, we basically turn the spigot on full force and then stick our thumb in the bottom to see if we can gain control, and that's not a very efficient way of doing it."

The AMA agrees with the GAO. Spending targets are inefficient and ineffective, and we recommend that where inappropriate volume growth is identified in a particular type of medical service, Congress, CMS, and organized medicine should address it through development of the mechanisms described in the "Joint Recommendations" referenced above. This would allow Congress and CMS to deal with the source of the increase, thereby ensuring more control over the process than exists under the current system.

Senator Stabenow:

Question: Do you believe that the physician community has been appropriately involved and adequately represented in the analysis of the current payment system and development of proposals for fixing the system?

The AMA has long been working with Congress to repeal the current SGR formula. We appreciate that Congress has acted in each of the last five years to forestall steep Medicare physician payment cuts, due to the flawed SGR. Yet, Medicare payments to physicians in 2007 are essentially the same as they were in 2001, and a cut of 10% is projected for 2008. Further, due to the SGR, physicians face drastic payment rate cuts totaling almost 40% over eight years (beginning in 2008), while physician practice costs will increase nearly 20% during that time period. These cuts come at a time when Medicare payments to physicians already lag far behind the cost of caring for seniors and just as the baby-boomers enter the Medicare program. (In 2010, the leading edge of the baby-boom generation will start enrolling in Medicare, with enrollment growing from 43 million in 2010 to 49 million by 2015.)

Only physicians and other health professionals (whose payment rates are tied to the physician fee schedule) face these steep payment cuts. Other Medicare providers' payment updates have kept pace with their costs increases. Physicians and other health care professionals must have payment updates that keep pace with their cost increases, similar to the updates for other providers. A 2006 AMA survey showed that patient access will suffer as a result of the cuts.

We agree that continued physician involvement in the development of a new payment update formula is critical, and we look forward to continuing to be invited to participate in this process. Physicians have a solid track record in working toward high-quality, cost-effective care. For example, the AMA convened the Physicians' Consortium for Performance Improvement in 2000 for the development of performance measurements. Through the Consortium, physicians have had exceptional success in developing physician-level performance measures and the Consortium has become the leading physician-sponsored initiative in the country. To date, the Consortium has developed 174 performance measures and 59 of the 74 measures in Medicare's PQRI came from the Consortium.

The physician community has also come together to address the appropriate use of physicians' services. Our efforts are reflected in the "Joint Recommendations" discussed above." **We look forward to continuing to work with Congress and CMS to develop a system that adequately reflects medical practice cost increases and assures appropriate use of high quality medical services.**

Question: MedPAC's Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System (March 1, 2007) does not make specific recommendations. Does Congress have the information we need to move forward with establishing a new payment system at this point? If not, what other information do we need?

MedPAC, in its regular March Report to Congress (for 2007), has recommended that Congress establish a Medicare physician payment update for 2008 that reflects medical practice cost inflation, which would be 1.7%. The AMA strongly supports this recommendation, and urges the Committee and Congress to avert next year's projected 10% cut and replace it with a positive 1.7% payment update. This is critical since physician payment updates have not kept up with practice cost increases for the last six years.

Further, MedPAC's March 1, 2007 SGR Alternatives Report to Congress describes a number of reasons for abandoning the SGR, and we believe that MedPAC has provided Congress with sufficient information to support a policy of eliminating the SGR. We are committed to working with Congress and CMS to help assure the appropriate use of medical care, as discussed above in our "Joint Recommendations." **We urge Congress to repeal the SGR and replace it with Medicare physician payment system that that adequately reflects medical practice cost increases and assures appropriate use of high quality medical services. Congress has already put a system in place for hospitals, nursing homes, and other providers which have positive payment updates reflecting medical inflation. The same approach should be used for physicians' services. This is fundamental for assisting physicians in investing in the HIT and quality initiatives that Congress and policymakers envision for delivering the highest quality of care to our Medicare patients.**

Question: How can we determine whether the volume of physician services currently being provided, and projected under different payment systems, is appropriate or inappropriate?

As discussed above, the AMA, along with 76 organizations representing physicians and other health professionals, has developed "Joint Recommendations to Congress on Eliminating the SGR and Supporting Efforts to Promote Health Care Quality and Appropriateness." These "Joint Recommendations" call on Congress to support initiatives by the profession to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries. The AMA is committed to working with Congress, CMS, and MedPAC to develop techniques to assure the appropriateness of services, while repealing the SGR and ensuring a stable Medicare program that delivers to our seniors and disabled patients high quality, cost-effective health care services.

Question: The returns of health IT accrue to the payers and patients, but providers must pay for the acquisition and implementation of these systems – which can be very expensive. How can the federal government encourage adoption of health information technology for Medicare providers?

Despite considerable physician interest for the improved quality and efficiency that many predict HIT can bring to the practice of medicine, substantial economic barriers exist. In fact, a study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider, and ongoing costs were about $8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider.

These substantial costs should not be primarily imposed on physicians. It would only exacerbate the fact that physician payment rates are about the same in 2007 as they were in 2001, and with pending cuts of 40% in Medicare payment rates over the next eight years, physicians will not be able to make the significant financial investment needed for effective HIT implementation. Further, physician investment in HIT will substantially benefit "downstream" players, such as payers (including the federal government), private insurance and employers, providers, and patients. In fact, according to David Bates, Director of Clinical and Quality Analysis of Partners Healthcare, only about 11% of benefits attributable to HIT investment inures to the investing physician or health care facility, with the remaining 89% going to payers and employers.

Because of this cost burden, it is critical that Medicare develop a stable payment system with annual positive physician payment updates that adequately reflect medical practice costs increases. Without an appropriate payment system that allows physicians to properly invest in HIT, policymakers' vision of an HIT- and quality improvement-based Medicare physician payment system will not be achieved.

The AMA, however, is encouraged that Congress has considered various proposals that contain some measure of financial assistance for physicians in their HIT adoption efforts.

The AMA strongly believes that current Medicare and Medicaid payment systems must be altered to allow individual physicians to share in the overall, system-wide savings that their expected investment in costly HIT systems will generate. Similarly, meaningful direct grants, low-interest loans, and tax and other economic incentives commensurate with the significant expense of creating a national health information network are essential. **We look forward to working with the Committee and Congress as we move to develop a Medicare physician payment system that uses HIT to help deliver high quality, low-cost medical services to our nations' senior and disabled patients.**

STATEMENT of the American Academy of Family Physicians

Submitted for the Record

to the

Senate Finance Committee

Concerning

Medicare's Physician Payment System

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Introduction

This statement is submitted on behalf of the 93,800 members of the American Academy of Family Physicians to the Senate Finance Committee as part of its hearings on Medicare Physician Payment held March 1, 2007. The AAFP appreciates the work this Committee has undertaken to examine how Medicare pays for the services that physicians deliver to beneficiaries. Family physicians also share the Committee's concerns that the current system is inefficient, inaccurate and outdated. For this reason, the AAFP supports the restructuring of Medicare payments to value appropriately quality improvement and care coordination. AAFP believes that this restructuring should be done with the needs of Medicare patients foremost in mind. Since most of these patients have two or more chronic conditions that call for continuous management and that depend on differing pharmaceutical treatments, Medicare should focus on how physicians can coordinate the care these patients need and prevent expensive and duplicative tests and procedures.

The recent MedPAC report falls short of offering achievable alternatives to the physician payment formula that would support the health care that Medicare beneficiaries need. The AAFP appreciates the difficulty of the assignment that Congress gave to MedPAC – any formula change is likely to be a daunting task. MedPAC Commissioners and staff worked diligently to tackle this assignment and we appreciate the degree to which they listened to the suggestions of the physician community, including family physicians. However, we are concerned that the recommendations are administratively unworkable and do not address the real problem with the Medicare payment formula that does not promote the effective coordination of care.

If Medicare is to provide the health care that its patients need, we must understand how health care is now provided to this population. Most people in this country, including Medicare patients, receive the majority of their health care in ambulatory care settings, i.e., in the office of their physician. About a quarter of all of these office visits in the U.S are to family physicians, and Medicare beneficiaries comprise about a quarter of the typical family physician's practice. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one. These are conditions which are managed with the physician's guidance and for which the patient adapts his or her behavior. Successful management of these conditions means fewer trips to the hospital and less expensive medical care. But currently, Medicare does not compensate physicians' practices for providing this management of care. Nor does Medicare compensate physicians' practices for coordinating the care that patients receive from a multitude of other health care providers.

Finding a more efficient and effective method of paying for physicians' services delivered to Medicare beneficiaries with a large variety of health conditions is a difficult but necessary endeavor, and one that has tremendous implications for millions of patients. The AAFP, therefore, is committed to participating in the design of a new payment system that meets the needs of these patients and the physicians who serve them.

The AAFP believes that there are three elements that should be part of the effort to make Medicare more responsive to quality improvement and efficiency of service. These are a patient-centered medical home, staged quality measurement and reporting, and general use of health information technology to collect and report that quality data.

Current Payment Environment
Before we examine where we could go with improving Medicare payment, let us recall where we are. The environment in which U.S. physicians practice and are paid is certainly challenging. Medicare, in particular, has a history of making disproportionately low payments to family physicians and other primary care physicians, largely because its payment formula is based on a reimbursement scheme that rewards procedural volume and fails to foster the comprehensive, coordinated management of patients that is the hallmark of primary care. More broadly, the prospect of steep annual cuts in payment resulting from the flawed payment formula is discouraging for all physicians. In the current environment, physicians know that, without annual Congressional action, they will face Medicare payment cuts in the range of 5-10 percent. Clearly, the Sustainable Growth Rate (SGR) formula does not work.

Under the SGR, physicians face steadily declining payments into the foreseeable future – nearly 40 percent over the next nine years – even while their practice costs continue to increase. According to the government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business which delivers medical care.

From the outset, the Medicare program has based physician payment on a fee-for-service system. This system of non-aligned incentives rewards individual physicians for ordering more tests and performing more procedures. The system lacks incentives for physicians to coordinate the tests, procedures, or patient health care generally, including preventive and health-maintenance services. This payment method has produced expensive, fragmented health care.

The Patient-Centered Medical Home
To correct these inverted incentives, the American Academy of Family Physicians recommends that Medicare compensate physicians for care coordination services. Such payment should go to the personal physician chosen by the patient to perform this role. Any physician practice prepared to provide care coordination could be eligible to serve as a patient's "personal medical home."

The AAFP, the American College of Physicians (ACP), the American Osteopathic Association (AOA) and the American Academy of Pediatrics (AAP), who combined represent 333,000 physicians, have been working with the National Committee for Quality Assurance (NCQA) to develop a recognition program for those physician practices that want to serve as a "patient-centered medical home." We would recommend that once this process is completed, Congress might make a physician practice eligible for a per-patient, per-month care management "medical home" fee if that practice has received independent recognition by NCQA or another non-profit third party. By linking the medical home fee to this voluntary validation process, the federal government and Medicare beneficiaries can be assured that the physician practice will have met rigorous standards of service.

The AAFP recommends that Medicare support a patient-centered medical home because it will not only improve quality but also make delivery of health care more efficient. An efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more effective use of resources and that result in better health outcomes. For example, the work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly, who have a usual source of

care, similar to a medical home, are healthier and the cost of their care is lower because they use fewer medical resources than those who do not. The evidence shows that even the uninsured benefit from having a usual source of care (or medical home). These individuals receive more appropriate preventive care and more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when they need it. A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is eliminated.

The AAFP commends Congress for incorporating the medical home demonstration into the Medicare physician payment provisions of the *Tax Reform and Health Act* passed by the 109th Congress. While there is much to learn and much to investigate through this demonstration, we know enough about the value of the medical home to incorporate its provisions into the reform of the Medicare payment formula. Because of the strength of the existing literature describing the effectiveness (both health and economic) of the medical home, AAFP would urge the committee to authorize the Centers for Medicare and Medicaid Services (CMS) to adopt the Patient-centered Medical Home as an interim component of physician payment while awaiting the implementation of and results from the demonstration project.

The patient-centered, physician-guided medical home being advanced jointly by the AAFP, the ACP, the AOA, and the AAP would include the following elements:

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- ***Quality and safety*** are hallmarks of the patient-centered medical home:
    - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

- ***The payment structure*** appropriately recognizes the added value provided to patients who have a patient-centered medical home. To do this, the payment should:
  - reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the traditional face-to-face visit;
  - pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
  - support adoption and use of health information technology for quality improvement;
  - promote enhanced communication access such as secure e-mail and telephone consultation;
  - recognize the value of physician work associated with remote monitoring of clinical data using technology;
  - allow for separate fee-for-service payments for face-to-face visits (i.e., payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);
  - recognize case mix differences in the patient population being treated within the practice.
  - allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office.
  - add payments for achieving measurable and continuous quality improvements.

An Example: Community Care of North Carolina
One model that the Committee could well consider that clearly demonstrates the benefits of a Medicare payment system that is based on the patient-centered medical home the Medicaid program in North Carolina, headed by a family physician, Dr. Allen Dobson.

Community Care of North Carolina (CCNC) is a Medicaid care-management program that has demonstrated significant cost savings, improved health outcomes, and increased access to care for almost 700,000 Medicaid beneficiaries.

Community Care of North Carolina consists of 15 local networks across the state, including more than 3,000 physicians practicing in collaboration with local health departments, hospitals, social service agencies, and other community providers, that manage the care of about 74 percent of all eligible Medicaid beneficiaries in the state.

CCNC has become a proven model of community-based, integrated care coordination and management. The core belief guiding the provision of health care to underserved populations is that if improvement in health care and service is the goal, those responsible for making it happen must have true ownership of the improvement process. It has achieved this goal along with considerable cost savings.

According to an independent cost effectiveness analysis performed by Mercer, CCNC spent $203 million less than what the fee-for-service Medicaid program would have spent for the same population in 2003. The following year, that figure was estimated at $225 million less than fee-for-service Medicaid.

An evaluation of CCNC disease management initiatives performed by the University of North Carolina found the costs to CCNC of caring for Medicaid patients with asthma and diabetes to be much less than for those Medicaid patients served in the traditional Medicaid managed care program. The study concluded that over three years (2000-2002) the state would have saved about $3.3 million for CCNC enrollees with asthma (especially individuals 45 years of age and older) and approximately $2.1 million for CCNC patients needing diabetes care, both associated with significant changes in utilization and other practice measures (e.g., reduction in hospital emergency room visits). The evaluation focused primarily on the effects of disease management and adherence to practice guidelines. In 2006-2007, CCNC plans to implement additional disease management programs, including managing enrollees with congestive heart failure and chronic pulmonary disease. In 2005, four local CCNC networks also began piloting a collaborative approach to managing Medicaid enrollees with both behavioral and physical health needs to serve them in the most appropriate setting.

Improving Quality

Beyond replacing the outdated and dysfunctional SGR formula, a workable, predictable method of determining physician reimbursement - one that is sensitive to the costs of providing care - should align the incentives to encourage evidence-based practice and foster the delivery of services that are known to be more effective and result in better health outcomes for patients. Moreover, the reformed system must facilitate efficient use of Medicare resources by paying for appropriate utilization of effective services and not paying for services that are unnecessary, redundant or known to be ineffective. Such an approach is endorsed by the Institute of Medicine (IOM) in its 2001 publication *Crossing the Quality Chasm.*

Another IOM report, released in 2006 entitled *Rewarding Provider Performance: Aligning Incentives in Medicare,* states that aligning payment incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans. The objective of aligning incentives for quality improvement is to support: (1) the most rapidly feasible performance improvement by all

providers; (2) innovation and constructive change throughout the health care system; and (3) better outcomes of care, especially through coordination of care across physician practice settings and over time. The AAFP concurs with the IOM recommendations:

- Measures should allow for shared accountability and more coordinated care across physician practice settings.
- Quality measurement programs should reward care that is patient-centered and efficient, and reward providers who improve performance as well as those who achieve high performance.
- Providers should be offered incentives to report quality measures.
- Because electronic health information technology will increase the probability of a successful quality measurement program, Medicare should explore ways to assist physicians in implementing electronic data collection and reporting to strengthen the use of consistent measures.

Aligning the incentives requires collecting and reporting data through the use of meaningful quality measures. AAFP supports collecting and reporting quality measures and has demonstrated leadership in the physician community in the development of such measures. It is the Academy's belief that measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based and physicians should be directly involved in determining the measures used for assessing their performance.

Reporting Quality

AAFP supports collecting and reporting quality measures to improve patient care and has led the physician community in the development of meaningful and useful measures. Consistent with the philosophy of aligning incentives, the reward for collecting and reporting data must be commensurate with the effort and processes necessary to comply and must be sufficient to obtain the desired response from physicians. The Academy is skeptical that the incentive of 1.5 percent of a physician's Medicare allowed charges for collecting and reporting quality measurement data will be sufficient to cover the actual cost of operationalizing such a program. We also remain concerned that the program does not focus first on providing physician practices with the information technology needed to make meaningful reporting and data collection possible.

Nonetheless, we support the policy of building in payment incentives for quality reporting and improvement. The AAFP helped establish the Ambulatory Care Quality Alliance (AQA), which is an essential part of the physician-led process to develop, evaluate and implement quality improvement measures for physician practices. Together with the Physicians Consortium for Performance Improvement and the National Quality Forum, the AQA helped implement a starter set of 26 quality measures for physicians who provide primary health care. The AQA continues to work with the Consortium and NQF as they develop and review additional measures of quality for primary care physicians.

Information Technology in the Medical Office

The AAFP believes that quality, access and positive health outcomes must be the primary goal of any physician payment system. Prevention, early diagnosis and early treatment will simultaneously improve quality of life and ultimately save valuable health

care dollars. But implementing data collection and reporting requires an initial investment from the health care provider in the form of electronic data and decision support systems. The AAFP urges the Committee to explore ways of making funding available for small physician practices to obtain and maintain adequate electronic health records and other tools that will enable such collection and reporting without the considerable administrative burden we fear it will be.

Using advances in health information technology (HIT) also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting – two additional goals of recent IOM reports. We have learned from the experience of the Integrated Healthcare Association (IHA) in California that when physicians and practices invested in electronic health records (EHRs) and other electronic tools to automate data reporting, they were both more efficient and more effective, achieving improved quality results at a more rapid pace than those that lacked advanced HIT capacity.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology (CHiT). The AAFP created the CHiT in 2003 to increase the availability and use of low-cost, standards-based information technology among family physicians with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. Since 2003, the rate of EHR adoption among AAFP members has more than doubled, with over 30 percent of our family physician members now utilizing these systems in their practices.

In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. CHiT used this information to develop a practice assessment tool on its Website (http://www.centerforhit.org/), allowing physicians to assess their readiness for EHRs.

In any discussion of increasing utilization of an EHR system, there are a number of barriers and cost is a concern for family physicians, especially those in small and medium sized practices. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program to lower the prices of appropriate information technology. The AAFP's Executive Vice President serves on the American Health Information Community (AHIC), which is working to increase confidence in these systems by developing recommendations on interoperability. The AAFP sponsored the development of the Continuity of Care Record (CCR) standard, now successfully balloted through the American Society for Testing and Materials (ASTM). We initiated the Physician EHR Coalition, now jointly chaired by ACP and AAFP, to engage a broad base of medical specialties to advance EHR adoption in small and medium size ambulatory care practices. In preparation for greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of this year.

To accelerate reporting, the AAFP joins the IOM in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health & Human Services, billions of dollars will be saved each year with the wide-spread adoption of HIT systems. The federal government has already made a financial commitment to this technology; unfortunately, the funding is not directed to the systems that will truly have the most impact and where ultimately all health care is practiced - at the individual patient level. We encourage Congress to include funding in the form of

grants or low interest loans for those physicians committed to integrating an HIT system in their practice.

Conclusion
It is time to modernize Medicare by recognizing the importance of, and appropriately valuing, primary care and by embracing the Patient-centered Medical Home model as an integral part of the Medicare program.

Specifically, the AAFP encourages Congressional action to reform the Medicare physician payment system in the following manner:

- Repeal the Sustainable Growth Rate formula at a date certain and replace it with a stable and predictable annual update based on changes in the costs of providing care as calculated by the Medicare Economic Index.

- Adopt the patient-centered medical home by giving patients incentives to use this model and compensate physicians who provide this function. The physician whose practice has been recognized by an independent third party and designated by the beneficiary as his or her medical home shall receive a per-member, per-month care management fee in addition to payment under the fee schedule for services delivered.

- Phase in value-based purchasing by providing a bonus payment to physician practices that report data related to specific quality measures. This additional payment should cover costs associated with the program and provide sufficient incentive to report the required data. Move to payment for the use of information technology to collect and submit appropriate quality improvement data.

- Offer a program of low-cost loans to small and medium sized physician practices to purchase health information technology necessary to collect and report quality measurement data.

- Ultimately, payment should be linked to health care quality and efficiency and should reward the most effective patient and physician behavior.

The Academy commends the Committee for its commitment to identify a more accurate and contemporary Medicare payment methodology for physician services. Moreover, the AAFP is eager to work with Congress toward the needed system changes that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.

AOTA

The American Occupational Therapy Association, Inc.

Occupational Therapy: Skills for the Job of Living

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION SUBMITTED TO UNITED STATES SENATE COMMITTEE ON FINANCE FOR THE HEARING "MEDPAC'S ANNUAL MARCH REPORT" March 1, 2007

The American Occupational Therapy Association (AOTA) submits this statement for the record of the March 1, 2007 hearing. We appreciate the opportunity to provide comment.

Medicare payments to providers have seen continuous adjustments since the Medicare program was established in 1965. AOTA has concerns in regard to Medicare payment in several different areas. First, AOTA, and other provider and consumer groups have worked at great lengths with CMS and Congress to avoid the implementation of the Medicare Part B outpatient therapy caps in recent years. Also, inpatient rehabilitation facilities (IRF) are coming under new rules to change there patient mix to comply with rules set forth by CMS that require a certain percentage of the IRF's patients must be treated for one of thirteen specific conditions in order for the IRF to receive the Medicare payments for intensive rehabilitation . Finally, due to the fundamental flaws of the current Medicare physician payment update formula, called the sustainable growth rate or SGR, the Centers for Medicare and Medicaid Services (CMS) and Congress have engaged in discussions to replace or fix this complicated formula. AOTA believes the topic of this hearing will assist in efforts to fully maximize Medicare payments to get the best outcomes for Medicare beneficiaries. AOTA is pleased to provide comment on the state of Medicare payment for therapy services.

AOTA represents more than 36,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy is a health and rehabilitation service that helps individuals whose lives have been affected or could be affected by injury, disease, disability or other health risk. Clients who benefit from occupational therapy include infants and children, working age adults, and older persons who are dealing with conditions affecting their ability to engage in everyday activities or "occupations." Occupational therapy is a covered Medicare service for treatment of an illness or injury to recover or improve function. Occupational therapy is also a covered professional service under Medicaid, SCHIP programs, private health insurance, workers' compensation, and other programs.

AOTA is appreciative of the overwhelming support demonstrated by Congress' cosponsorship of the Medicare Access to Rehabilitation Act, which would repeal the therapy caps. Occupational therapists, therapy assistants, and beneficiaries face uncertainty every year that the financial limitations on therapy imposed by Congress in the Balanced Budget Act of 1997 remains in place. The legislation imposed a $1500 annual cap on Medicare Part B outpatient occupational therapy alone and physical therapy and speech-language pathology combined. A 1-year extension of the exceptions process was

included in the Tax Relief and Health Care Act of 2006 [P.L. 109-432], however, that will expire on December 31, 2007 unless Congress takes action this year. AOTA supports passage of legislation that would repeal the caps, and is dedicated to work with CMS, Congress, and other provider and consumer groups to find an appropriate long-term solution. In past reports, MedPAC has expressed concerns with the caps because they do not discriminate between necessary care and unnecessary utilization. AOTA would like to know if MedPAC has any recommendations on how CMS might refine the exceptions process to ensure that patients continue to receive appropriate care, but still allow CMS to deter unnecessary services or overutilization. Financial limitations to proper therapy services impede the therapists' ability to care for their patients appropriately and use professional judgment effectively, and ultimately hinder the ability of a therapist to provide high- quality, efficient care to Medicare beneficiaries.

Another area of Medicare payment that is of concern to AOTA is the impending implementation of the "75% Rule." The 75% Rule is a federal Medicare regulation that sets arbitrary limits on the types of patients who are qualified for admission to a rehabilitation hospital or unit. These arbitrary percentages override the clinical judgment of the treating physician and rehabilitation provider team. The 75% rule for IRFs requires that a percentage of patients must be treated for one of thirteen specific conditions identified in 1984 in order for a facility to retain IRF status. The list of conditions is viewed by most as outdated, failing to take into account medical advances of the past two decades and changing patient needs. The rule has widely been viewed as not applicable due to inconsistencies in accurately determining medical necessity. IRF status gives the hospital the ability to receive adequate Medicare compensation due to the intense rehabilitation services that are provided. Some rehabilitation programs are downsizing and by CMS' own estimate, shift thousands of patients – both Medicare and non-Medicare – into alternative care settings that may be inappropriate and inadequate. Most recently, the Deficit Reduction Act of 2005 provided a one-year extension on the phase-in of the inpatient rehabilitation facility (IRF) classification criteria – or "75% rule." The bill retains the 60% threshold for 2006, a 65% threshold for 2007, and will begin the 75% rule in 2008. AOTA supports the Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007 which will lock the percentage in at 60%. This legislation is essential to the occupational therapy profession, the continued viability of inpatient rehabilitation hospitals and units, and is necessary to ensure that Medicare beneficiaries and others continue to have access to intense rehabilitative care in the appropriate inpatient setting.

AOTA is also concerned about the flawed SGR formula that determines the physician fee schedule. Occupational therapists are paid under the physician fee schedule and are subject to the yearly adjustments based upon the SGR. AOTA is looking forward to working with Congress and CMS as the Physician Quality Reporting Initiative moves forward. There will need to be specific insight and participation by AOTA in order to ensure proper representation of rehabilitation in any future pay-for-performance payment system.

AOTA commends the Subcommittee on taking the time to discuss Medicare payments. AOTA looks forward to working with CMS and members of Congress to better our nation's healthcare system.

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